JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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VOLUME 50, NUMBER 10

OCTOBER, 1960

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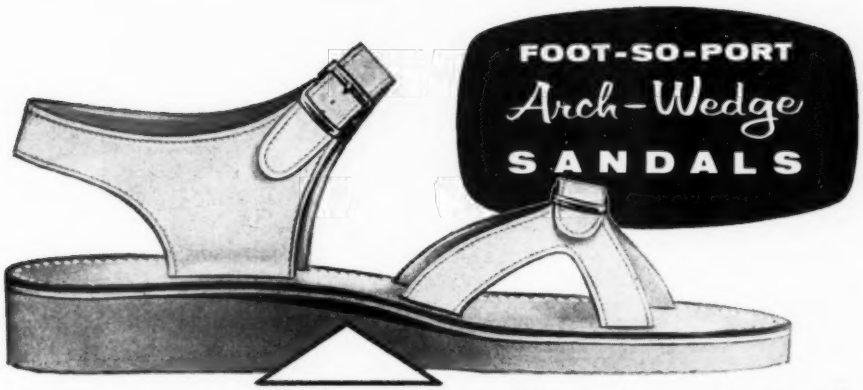

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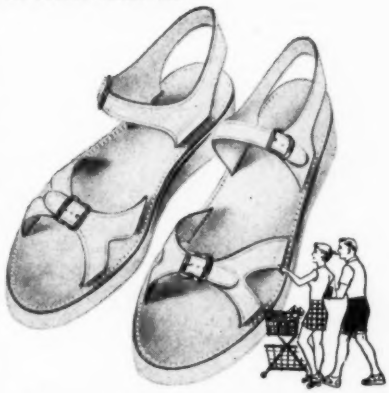

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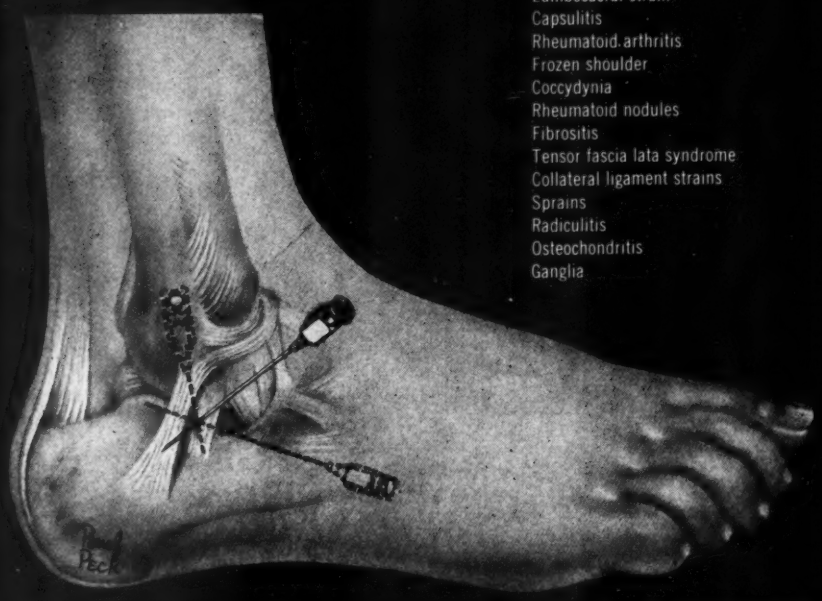

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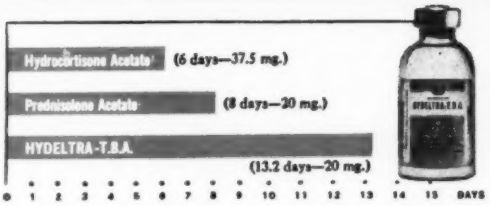
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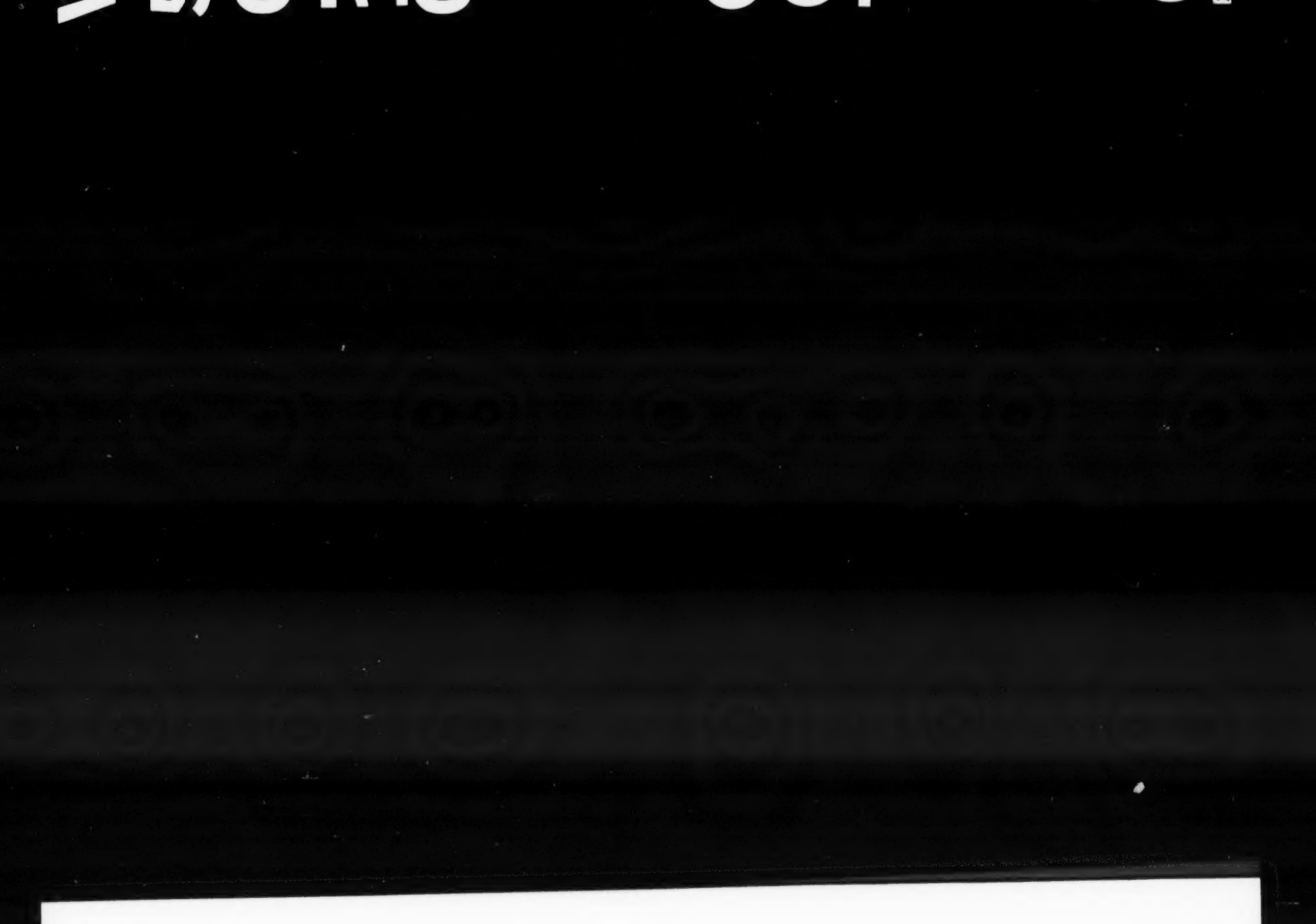

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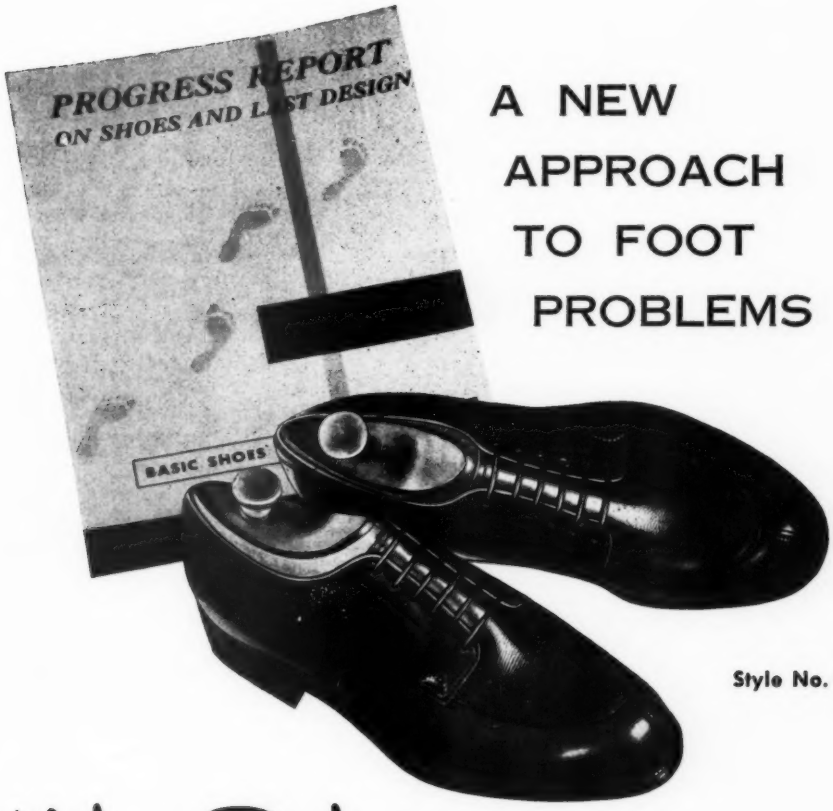

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1. Sokoloff, O.: A.M.A. Arch. Dermat. and Syph. *64*:754, 1951. 2. Van De Erve, J.: A.M.A. Arch. Dermat. and Syph. *68*:572, 1953. 3. Bleiberg, J.: personal communication. 4. Tobey, J.: personal communication.

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Nebraska Association of Chiropodists	L. G. Lefler, 239 W. 6th, Fremont, Nebr. Paul M. Kucera, 602 Medical Arts Bldg., Omaha, Nebr.
Nevada Association of Chiropodists	Wilbur W. Sylvester, 321 S. 5th St., Las Vegas, Nev. William A. Edwards, 150 No. Arlington Ave., Reno, Nev.
New Hampshire Podiatry Association	Arthur J. Bosa, 51 Main St., Keene, N. H. T. M. Levingston, 39 Pleasant St., Portsmouth, N. H.
New Jersey Chiropodists' Society	Mario V. Calligaro, 304 Parker Ave., Clifton, N. J. Jack Horwitz, 463 High St., Burlington, N. J.
New Mexico Podiatry Society	E. Lenore Morris, 809 Silver Ave., S. W., Albuquerque, N. Mex. C. W. Boesenberg, 922 Tijeras Ave., N.W., Albuquerque, N. M.
New York, The Podiatry Society of the State of	Milton Werbel, 55 W. 42nd St., New York, N. Y. G. Hollander (Ex. Sec.), 353 W. 57th St., New York, N. Y.
North Carolina Podiatry Society	Donald J. Cameron, 504 Murchison Bldg., Wilmington, N. C. Carlos T. Cooper, Jr., 303A Reynolds Bldg., Winston-Salem, N. C.
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Oklahoma Chiropody Association	Jeane L. Johnson, 510 W. Broadway, Enid, Okla. H. R. Johnson, 401 N. Beard St., Shawnee, Okla.
Oregon Podiatry Association, Inc.	George McCauley, 4126 N. E. Broadway, Portland, Ore. William V. Wheeler, 405 High St., N. E., Salem, Ore.
Pennsylvania, Chiropody Society of	Joseph D. Fletcher, 520 Temple Bldg., New Castle, Pa. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa.
Rhode Island Podiatry Society	Edward L. Hochman, 452 Main St., Pawtucket, R. I. Leonard H. Lerner, 1045 Warwick Ave., Warwick, R. I.
South Carolina Podiatry Association	James D. Hill, 122 W. Whitner St., Anderson, S. C. H. A. McAninch, 169 Hall St., Spartanburg, S. C.
South Dakota Association of Chiropodists	M. D. Scofield, 120 W. 11th St., Sioux Falls, S. Dak.
Tennessee Chiropody Association	Richard J. Koch, 1203 Warner Bldg., Nashville, Tenn. Ronald E. Fields, 524 Bennie Dillon Bldg., Nashville, Tenn
Texas, Chiropody Society of	Ben Smith, Jr., 737 Wilson Bldg., Dallas, Tex. J. Gordon Russell, Goodhue Bldg., Beaumont, Tex.
Utah State Association of Chiropodists	Ralph Self, Boston Bldg., Salt Lake City, Utah Howard Jasperson, Judge Bldg., Salt Lake City, Utah
Vermont Chiropody Association	Gray S. Clark, 128 Merchants Row, Rutland, Vt. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Virginia, Podiatry Society of	Herman Chapel, New Monroe Bldg., Norfolk, Va. I. Leonard Kaplan, 718 Court St., Portsmouth, Va.
Washington State Podiatry Association	R. A. Watters, 1306 N. Eye St., Tacoma, Wash. Kurt Blau, 501 Medical Arts Bldg., Tacoma 2, Wash.
West Virginia, Chiropody Society of	Malcolm P. Iams, 716 Juliana St., Parkersburg, W. Va. G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va.
Wisconsin Society of Chiropodists	Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wisc Michel M. Addis, Med. Arts Bldg., 945 N. 12 St., Milwaukee 3, Wis.
Wyoming Podiatry Society	E. O. King, Odd Fellows Bldg., Casper, Wyo. Duane NeuSchultz, 2201 West A, Torrington, Wyo.

Affiliated Organizations

Women's Auxiliary A.P.A. (N.A.C.)—Mrs. Cleotha Parham, 5328 E. 26th St., Tulsa, Okla.
Military Association of Podiatrists—Lt. John L. Charlton, Jr., D.S.C., Podiatry Clinic, Walter Reed Army Hospital, Washington, D. C.
American College of Foot Surgeons—J. M. Kohl, 3959 No. Lincoln Ave., Chicago 13, Ill.
American Society of Chiropodical Roentgenology—Joseph L. Starr, 1115 Main St Bridgeport, Connecticut
Chiropody Bibliographical Research Society—S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa
American College of Foot Orthopedists—L. B. Thompson, 5613 7th Ave., Kenosha, Wisc.
American Association of Hospital Podiatrists—H. Charles Lilienfeld, 101 W. 57th St., New York, N. Y.
American Podiatry Students Association—Hal Anderson, 08150 Valley Rd., Lombard, Ill.
American Board of Chiropodical Dermatology—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

Related

Federation of Chiropody-Podiatry Boards—L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
American Association of Colleges of Chiropody—Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.
National Board of Chiropody Examiners—Pierce B. Nelson, 1770 Eddy St., San Francisco, Cal.
American Academy of Chiropodists—Robert Smith, 77 James St. North, Hamilton, Ontario 10, Canada.
Academy of Podiatry—Louis Lewy, 285 Madison Ave., New York, N. Y.
American Podiatry Council—L. J. Friedman, 1186 Broadway, New York, N. Y.
Fellows Pedic Research Society—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

ACCREDITED COLLEGES

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1770 Eddy Street
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"DERMATOLOGICAL DILEMMAS OF THE FEET AND LEGS"

Bruce Butler, Jr., Capt., M.C., U.S.A., Walter Reed General Hospital, Chief Orthopedic Resident

John L. Charlton, Lt., M.S.C., U.S.A., Walter Reed General Hospital
"NEOPLASTIC LESIONS OF THE FEET"— *Case presentations of neoplastic lesions of the feet as seen at Walter Reed General Hospital during the past five years.*

John A. Hennesson, Lt. Col., U.S.A.F. (MC), Chief of Orthopedics, U.S.A.F. Hospital Andrews, Andrews A.F.B., Washington, D. C.

Louis Burger, D.S.C. (Katzoff Memorial Lecture)
"LEG BRACES IN PODIATRIC CARE"

Herbert F. Hasenclever, Ph.D., Scientist, Commission Corps, United States Public Health Service, National Institutes of Health
"MYCOLOGICAL AND CLINICAL ASPECTS OF TINEA PEDIS"

William R. Felts, Jr., M.D., Assistant Professor in Medicine, George Washington University Hospital;
"GOUTY ARTHRITIS"

Alec C. Levin, D.S.C., Staff Member, Doctors Hospital
"A PRACTICAL APPROACH TO OFFICE SURGERY"

Richard O. Schuster, Pod.D.—Joseph Nemiroff, Pod.D.
"A STANDARDIZED METHOD OF EVALUATING GAIT AND STANCE" A—In Adults — B—In Children

Mary Lou Barker, M.D., Member American Board of Anesthesiology
"LOCAL ANESTHETIC REACTIONS—DIAGNOSIS AND TREATMENT"

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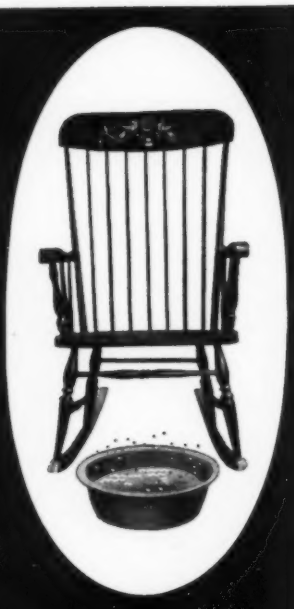

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STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

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Arizona

The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively in Sacramento, Oct. 17-20, 1960. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually January 17, 18, 1961, and July. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee will meet for reciprocity and examination in June 1961 at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Fredric B. Selke, Room 109, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.

Louisiana

Louisiana State Board of Medical Examiners will meet for examination Dec. 8-10, 1960, at Louisiana State University Medical School. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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STATE BOARD *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board will meet for examination Dec. 12, 1960, at Columbus, Ohio. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners will meet for examination in July, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Chiropody Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Kenneth D. Graves, M.D., 631 First St., S.W., Roanoke, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

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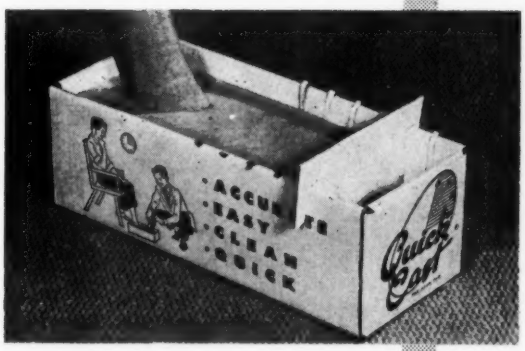

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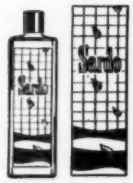

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1. Steinberg, M.D.: J. Amer. Podiatry Assn., June 1960.
2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.
3. Prentice, H. and Brezak, S.: J. Amer. Podiatry Assn., May 1958.

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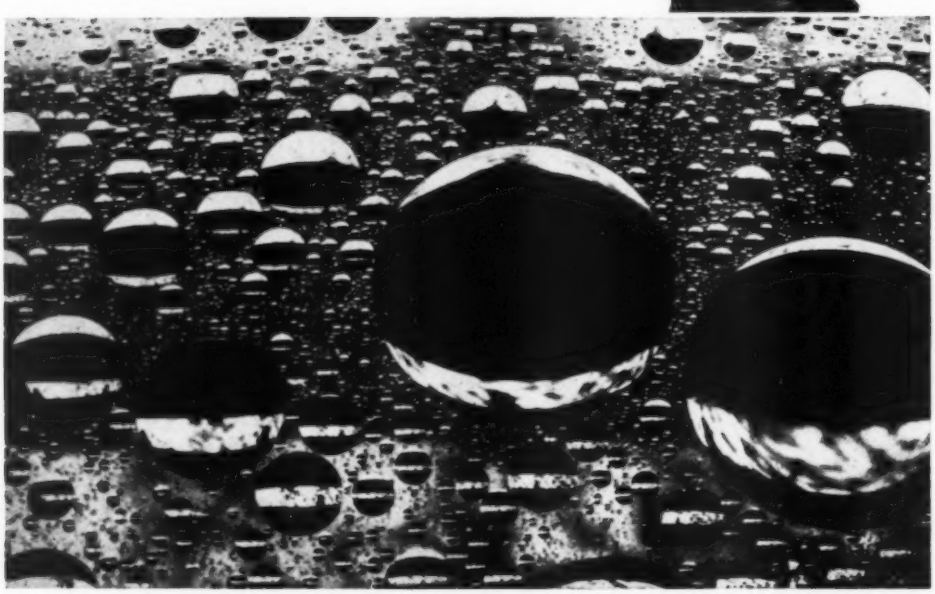

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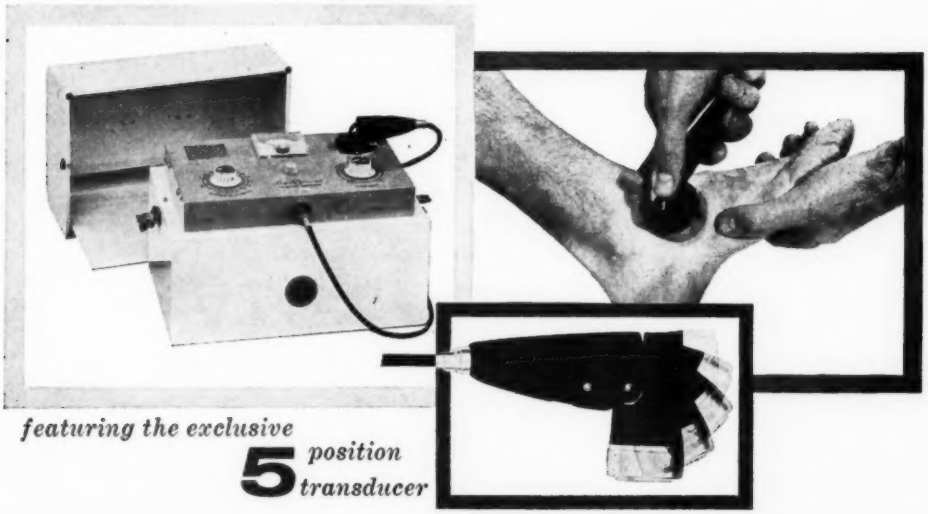

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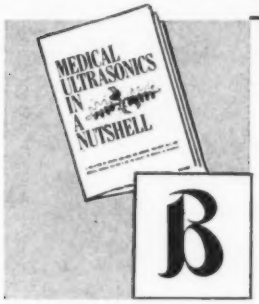

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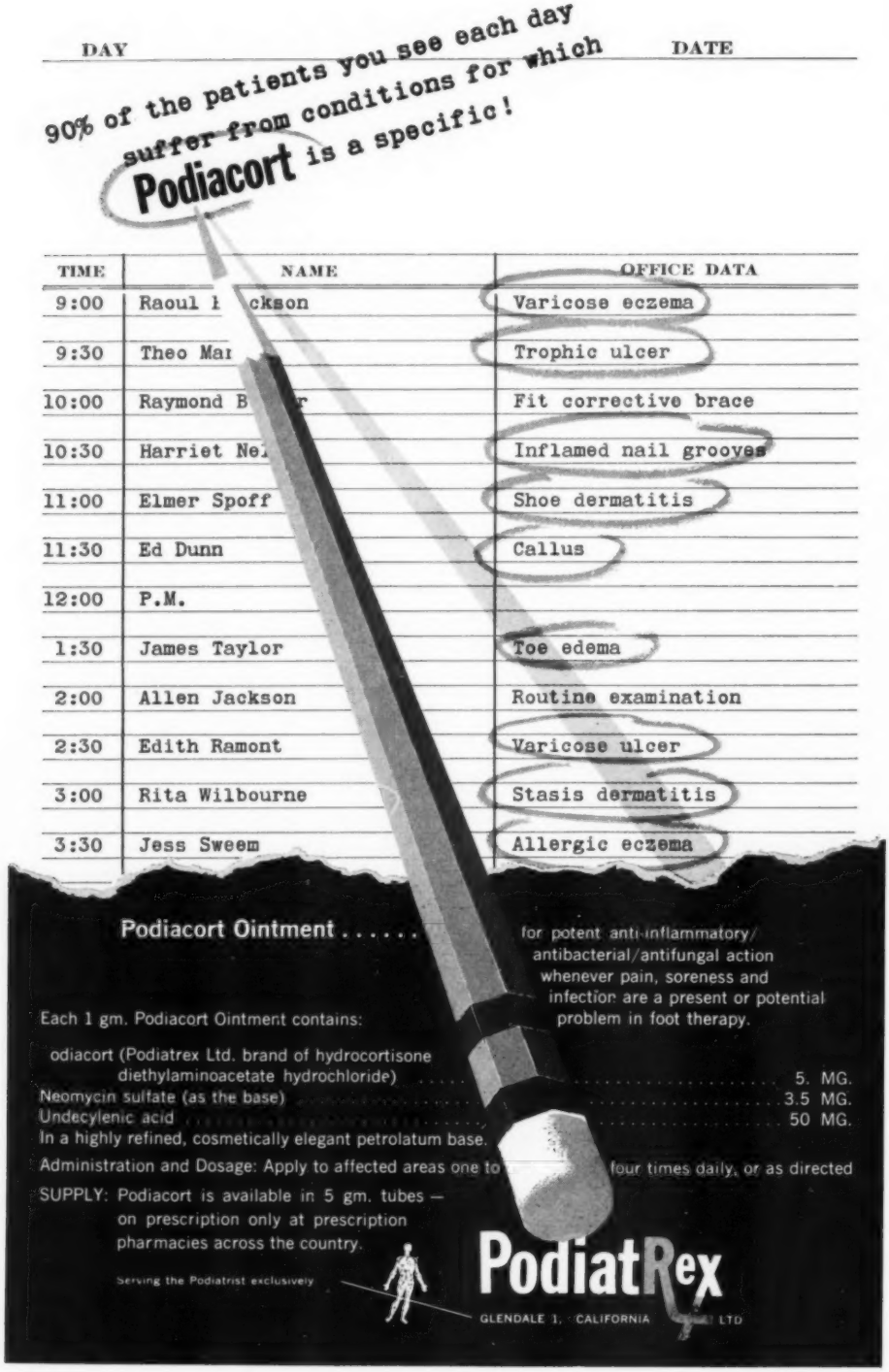
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THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

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INDUCED POSTURAL CHANGES RESULTING FROM ORTHOPEDIC PROGRAMMING*

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Introduction and Need for Study

THE podiatrist sees patients of all ages with musculoskeletal problems, and attention has been called to such difficulties by experts in several professional fields. For example, Stafford[4] estimates that 70-80% of our school children are in need of remedial posture work; Sherwood[3] found pronation in the feet in more than 70% of Junior High School girls studied; and Kraus[2] has mentioned the need for exercises in treating the musculoskeletal syndrome of adults. Even though individuals of all ages and both sexes are included, the podiatrist is seeing many old patients with, or whose symptoms are indicative of, foot and postural difficulties. It seemed significant to investigate the possibilities of postural changes through attention of the feet, and the possibility, therefore, of prevention of actual foot and posture difficulties as well as other health problems based, perhaps, in these types of difficulties.

The skeletal alignment of the body is the result of the mechanical relationship of all parts of the bony structure, and since the feet are the base of this alignment they play an important part in the whole postural result. If the feet, then, can aid in postural change the podiatrist has tremendous possibility for improving specific and general health of his patients, and, further, if such changes were to be made in children and young adults the podiatrist might well be instrumental in lessening or eliminating many musculoskeletal and other problems of the aging population. This would indeed be preventive and constructive medicine and a very real improvement in health for the older patient.

Purpose of the Study

To investigate the effect of orthopedic programming upon the posture of podiatric patients.

Basic Assumptions

1. Many musculoskeletal problems in the aged are results of faulty posture or body-mechanics.

2. Foot imbalance is one cause of faulty posture of body-mechanics.

*An award winning paper in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960. Presented at the Annual Meeting of the A.P.A., Drake Hotel, Chicago, Ill., August 1960.

3. Proper orthopedic programming can influence postural changes.

4. If valuable postural changes can be made in the aged, then proper podiatric-orthopedic programming is definitely valuable in the field of geriatrics through relief of symptoms and improvement of body mobility in older persons.

5. If correction of postural difficulties can be made in individuals during childhood, musculoskeletal problems in the aged may well be prevented or minimized.

TABLE I

CHANGES OBSERVED IN KYPHOSIS*

Case No.	Improved 0.3+	Improved Slightly 0.1-0.2	No Change	Poorer 0.3+	Slightly Poorer 0.1-0.2	Age
1	—	0.2	—	—	—	50
2	0.5	—	—	—	—	54
3	0.5	—	—	—	—	65
4	—	0.2	—	—	—	15
5	0.7	—	—	—	—	44
6	0.3	—	—	—	—	16
7	—	—	0	—	—	55
8	—	0.1	—	—	—	56
9	—	—	0	—	—	11
10	—	—	0	—	—	13
11	0.3	—	—	—	—	11
14	—	0.1	—	—	—	41
15	—	0.1	—	—	—	29
18	0.3	—	—	—	—	12
20	0.4	—	—	—	—	10
No.	7	5	3	0	0	

* All measurements are in mm

Method

Twenty-two podiatric patients of both sexes (ages 10 to 65 years) were included in the original study. Because two patients voluntarily dropped from the practice, another was in the hospital, a fourth was in an automobile accident, and photographic scheduling and technical difficulties eliminated three others — for these reasons, unrelated to the study data, the final study included 15 patients.

Each subject was photographed (frontal and left lateral views) upon the initial office visit and again after a program of orthopedic treatments had been applied. (Treatment program length varied from 4 to 14 months.) A #700 Polaroid camera with flash attachments was used on a tripod at a fixed height, 10 feet from the screen. The subject was positioned behind a posture screen with two-inch mesh, similar to the technique of Cureton[1]. The posture screen (both planes) was kept in horizontal position by means of two bubble-levels. A conformateur was used and appears in the lateral view photographs, although the data available from its back-delineation were not used in this study.

Four types of measurements were made on the original photographs, using Cureton's method; namely, kyphosis, lordosis,

TABLE II

CHANGES OBSERVED IN LORDOSIS*

Case No.	Improved 0.3+	Improved Slightly 0.1-0.2	No Change	Poorer 0.3+	Slightly Poorer 0.1-0.2	Age
1	0.7	—	—	—	—	50
2	0.6	—	—	—	—	54
3	0.7	—	—	—	—	65
4	0.5	—	—	—	—	15
5	0.3	—	—	—	—	44
6	—	—	0	—	—	16
7	—	0.1	—	—	—	55
8	—	—	—	0.3	—	56
9	0.4	—	—	—	—	11
10	—	—	0	—	—	13
11	—	0.2	—	—	—	11
14	—	—	0	—	—	41
15	—	—	0	—	—	29
18	—	0.2	—	—	—	12
20	—	0.2	—	—	—	10
No.	6	4	4	1	0	

* All measurements are in mm

TABLE III

CHANGES OBSERVED IN BODY BISECTION*

Case No.	Improved 0.3+	Improved Slightly 0.1-0.2	No Change	Poorer 0.3+	Slightly Poorer 0.1-0.2	Age
1	0.9	—	—	—	—	50
2	—	—	—	0.7	—	54
3	—	0.1	—	—	—	65
4	—	—	x	—	—	15
5	0.6	—	—	—	—	44
6	—	—	—	—	0.2	16
7	—	—	—	—	0.2	55
8	—	—	—	0.6	—	56
9	0.6	—	—	—	—	11
10	—	—	—	—	0.2	13
11	0.4	—	—	—	—	11
14	—	—	—	—	0.1	41
15	1.1	—	—	—	—	29
18	0.7	—	—	—	—	12
20	—	—	—	0.3	—	10
No.	6	1	1	3	4	

* All measurements are in mm

TABLE IV

CHANGES OBSERVED IN SHOULDER LEVEL*

Case No.	Improved 0.3+	Improved Slightly 0.1-0.2	No Change	Poorer 0.3+	Slightly Poorer 0.1-0.2	Age
1	0.7	—	—	—	—	50
2	—	—	—	—	0.1	54
3	—	—	—	—	0.2	65
4	0.4	—	—	—	—	15
5	—	—	—	0.6	—	44
6	0.3	—	—	—	—	16
7	—	0.1	—	—	—	55
8	—	0.2	—	—	—	56
9	0.4	—	—	—	—	11
10	0.6	—	—	—	—	13
11	—	—	—	—	0.1	11
14	—	—	—	0.3	—	41
15	—	—	—	—	0.2	29
18	—	0.2	—	—	—	12
20	—	—	x	—	—	10
No.	5	3	1	2	4	

* All measurements are in mm

body bisection (or bilateral symmetry) and shoulder height. Diagrams 1 and 2 in the appendix illustrate all four of the measurements utilized. Duplicates were made from the original photographs for inclusion in the appendix. Slight variations in size occurred in the duplications. Measurements were then made on the original photographs for compiling the tables.

A Vernier caliper, with mm scale, was used to make the measurements. One examiner performed all measurements. For greater accuracy in measuring, magnification of the photographs was effected by use of a magnifying glass in such fixed position as to give a double size to each photograph.

Results and Discussion

Fifteen patients were photographed (frontal and left lateral views) upon their initial office visit and again after participation in a program of orthopedic treatment. Vernier caliper measurements of kyphosis, lordosis, body bisection and shoulder height were made on the original photograph. Comparison of the measurements from the before-treatment and the after-treatment photographs showed distinct postural changes, most noticeable of which were found in the anteroposterior plane. In kyphosis, seven cases showed marked improvement, five cases showed slight improvement, and three subjects showed no change at all. Excellent results occurred in the lordotic measurements, with six cases showing marked improvement and four slight. Four cases were unchanged, while one increased in lordosis. Tables I and II illustrate these results.

The body bisection measurements indi-

TABLE V

ORIGINAL VERNIER MEASUREMENTS FROM PHOTOGRAPHS OF PODIATRIC PATIENTS*

Case No.	Shoulder Height Difference		Body Bisection at Neck				Kyphosis		Lordosis		Age	Time** Mos.
	1st	2nd	1st Right	1st Left	2nd Right	2nd Left	1st	2nd	1st	2nd		
1	0.7	0.0	1.4	2.8	2.0	2.5	2.2	2.0	3.0	2.3	50	13
2	0.8	0.9	2.6	2.5	2.9	2.1	2.4	1.9	3.2	2.6	54	12
3	0.6	0.8	1.9	3.2	2.2	3.4	3.6	3.1	2.8	2.1	65	13
4	1.1	0.7	3.5	1.9	3.5	1.9	3.9	3.7	3.7	3.2	15	12
5	0.0	0.6	1.9	2.7	2.4	2.2	2.3	1.6	2.3	2.0	44	14
6	0.8	0.5	2.8	2.8	2.5	2.7	2.6	2.3	2.4	2.4	16	6
7	0.7	0.6	2.6	2.6	2.4	2.6	2.4	2.4	1.7	1.6	55	14
8	0.5	0.3	2.6	2.8	3.3	2.5	3.0	2.9	1.9	2.2	56	14
9	0.9	0.5	2.8	1.9	2.6	2.3	2.1	2.1	2.9	2.5	11	4
10	0.7	0.1	2.0	2.7	1.9	2.8	2.2	2.2	2.5	2.5	13	14
11	0.6	0.7	2.7	1.4	2.5	1.6	2.8	2.5	1.8	1.6	11	4
14	0.5	0.8	2.1	2.3	2.0	2.3	3.1	3.0	3.2	3.2	41	13
15	0.3	0.5	3.6	2.1	2.7	3.1	4.0	3.9	2.0	2.0	29	4
18	1.2	1.0	3.4	1.2	2.6	2.1	1.8	1.5	2.3	2.1	12	6
20	0.4	0.4	2.4	2.3	2.1	2.5	2.1	1.7	2.2	2.0	10	6

* All measurements are in mm

** Time interval between measurements

cated six marked improvements, one slightly improved, and one with no improvement. Four were slightly poorer than when originally tested and three showed definitely poor results. The results from this aspect of the study do not appear to be as definite as those in the kypho-lordotic plane. However, changes in the lateral body balance (bilateral symmetry) did occur as a result of orthopedic-podiatric treatment. The period of treatment may not have been of long enough duration for complete bilateral symmetry to occur. Further study of this aspect is needed in order to more fully understand the resulting changes. Table III depicts these data.

The shoulder level differences improved greatly in five cases, and to a lesser degree in three subjects. One had no change, two were poor, and four were slightly poorer than on the original measurements. These figures being somewhat related to those of body bisection, tend to bear out the former results. See Table V for a comparison of the data.

Table V contains the basic data from which Tables I through IV were obtained. Adequate statistical treatment of the data was impossible due to the small number of cases involved in the study. It has been well demonstrated, however, that postural changes did occur after orthopedic-podiatric programming and that excellent results were found in the kypho-lordotic posture of the patients of all ages. In addition to the measured changes, creditable clinical evidence aided in verifying the

value of the results. The patient's subjective judgment and the podiatrist's objective assessment of the symptoms clearly demonstrated the value received by the patient. The changes in younger patients may indicate the value of early treatment as a means of preventing postural pathology during young adulthood and old age. Thus a healthier citizenry would occur at old age and many geriatric problems of foot, postural and musculoskeletal tension natures would be alleviated or prevented.

Summary and Conclusions

The postural changes due to orthopedic programming of fifteen podiatric patients aged 10-65 were studied. Vernier caliper measurements were made from erect frontal and left lateral photographs of each patient taken upon the initial office visit and after a period of orthopedic programming. Definite postural changes were observed. The greatest postural improvements were seen in kyphosis and lordosis. Some improvement occurred in body bisection (lateral symmetry) and shoulder height levels.

It may be concluded: (1) Postural changes can be measured in podiatric-orthopedic patients. (2) Postural changes occurred in the patients tested. (3) Kyphosis and lordosis were greatly improved according to the usual standards. (4) Shoulder height level and body-bisection improved, but to a lesser degree than kypho-lordosis. (5) Orthopedic-podiatric programming is valuable in making postural changes at ages 10-65, and probably at all ages. (6) The posture and well-being of geriatric patients can be improved through orthopedic-podiatric treatment.

3952 Fourth Ave.

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RUBEFACIENT THERAPY FOR THE FEET

MORTON H. WALKER, D.S.C.
Stamford, Conn.

A RUBEFACIENT is a medication which produces a mild local inflammation upon application to the skin. It is used in podiatry as a method of treatment against the second phase of inflammation which is stasis in both blood vessels and tissues. A rubefacient promotes resolution of blood stasis by encouraging absorption of the static exudate surrounding a truamatized area.

The ideal rubefacient has certain prerequisites for use on the foot. It is non-greasy and pleasant to use. It contains ingredients which are analgesic to relieve pain and pruritus. It acts as an antiphlogistic to stimulate a mild inflammation over a wide area and thus relieve congestion and stasis. It should be pleasant-smelling. It should be non-staining to clothing or bed linen. It must spread easily with light stroking of the skin. It causes a dilatation of the blood vessels by direct action on them. It penetrates the fatty layers and reaches the sensory nerve endings. Its constituents should promote absorption when the swelling of a joint takes place. It cannot be so counter-irritating that it would produce vesicle formation.

Banalg Liniment®[1] fits the requirements of the ideal rubefacient.

®[1] Cole Chemical Co, St. Louis, Mo.

The Composition of Banalg Liniment.

The qualitative pharmaceutical composition of Banalg Liniment is: menthol, camphor, methyl salicylate, oil of eucalyptus, in a non-greasy base.

Menthol is an alcohol obtained from oil of peppermint or other mint oils found in nature or prepared synthetically. It is a white crystalline substance, with a peppermint-like odor, whose molecular weight is 156.26 and whose molecular formula is $C_{10}H_{19}OH$. It is prepared from natural sources by cooling oil of peppermint to a low temperature and allowing the menthol to crystallize out. It is slightly soluble in water and very soluble in alcohol, chloroform and ether. Menthol is antiseptic and analgesic. When it is applied to the skin, it relieves pain, stimulates the nerve endings of cold, dilates the superficial blood vessels and is rubefacient. It is anti-pruritic and a counter-irritant.[1, 2, 3]

Camphor is a ketone obtained from the camphor tree or produced synthetically. It is a white crystalline mass with a pungent, aromatic odor and taste. It is soluble in water, 1 in 800; alcohol, 1 in 1; chloroform, 1 in 0.5; ether, 1 in 1, and freely soluble in fixed and volatile oils. Synthetic camphor is prepared by the fractional distillation of turpentine. Its molecular weight is 152.23 and its chemical formula is $C_{10}H_{16}O$. Camphor is used as a rubefacient, antipruritic, fungicide and antiseptic. When the substance is applied to the skin, it stimulates and then numbs the peripheral sensory nerves. It gives a sense of coldness owing to an increase in the sensitivity to cold of the skin's nerve endings. It has value as a counter-irritant in sprains and rheumatic conditions.[1, 2, 3]

Methyl salicylate is a distillation product of the wintergreen plant. It is also prepared synthetically by distilling salicylic acid and adding methyl alcohol and strong sulfuric acid. Its molecular weight is 152.14 and chemical formula is $C_8H_8O_3$. It is a colorless liquid with a characteristic wintergreen odor and taste. It is slightly soluble in water and alcohol. Methyl salicylate is antirheumatic, antipyretic and a counter-irritant. It is most effective when applied in conjunction with heat. It relieves congestion and muscle pain and may also be used to stimulate peripheral circulation.[1, 2, 3]

Oil of Eucalyptus is distilled from the fresh leaves of the plant Eucalyptus globus. Its chemical formula is $C_{10}H_{18}O$. It is a colorless or pale yellow liquid having a characteristic aromatic, somewhat camphoraceous odor and a pungent, spicy, cooling taste. It is soluble in 5 volumes of 70 percent alcohol. Eucalyptus Oil is used as an analgesic, antiseptic and healing agent, and as a deodorant.[1, 2, 3]

Banalg and External Heat

Banalg complements the effectiveness of heat producing modalities. The amount of heat given off by paraffin wax, diathermy, electric heating pads and infra-red lamps, when applied to the lower extremities is markedly increased by first coating the area with Banalg Liniment. In fact it is possible that too much heat may be produced. A bright erythema is created in the tissues with this combination. The patient sometimes finds the heat almost intolerable. But in no instance with the use of Banalg and superficial heat was vesicle formation witnessed. In most instances, melted paraffin was used with Banalg for five minutes and infra-red for ten, progressively moving the lamp away from the part. However, heat and Banalg must not be applied to any part where the circulation is so hindered that there is danger of local overheating.[4]

Banalg and Ultrasound

Ultrasound works well on a strained or sprained area with Banalg mixed with a coupling oil. The liniment is first applied to the injured part and mineral oil or baby lotion employed over that. Although ultra-

sound produces no sensation of its own, when used with Banalg a feeling of gentle warmth and penetration is experienced. The mini-massage of ultrasonics makes for a greater absorption of the rubefacient ingredients so that their effects are heightened. Ultrasonic therapy of 2 watts/Cm^2 for five minutes was used over a coating of Banalg on unbroken traumatized areas.

Banalg and Galvanism

Selected cases of myositis, sprains, trauma, chronic neuralgia and arthritis were treated with medical galvanism and Banalg Liniment. It was especially effective as an alternative treatment where patients were sensitive to heat. The galvanic current in conjunction with Banalg increased circulation, reduced nerve irritability, speeded up the resolution of inflammation and produced a mild heat. The positive pole was most useful. The current was raised to 10 milliamperes for ten minutes.[5]

Banalg and Massage

By far the greatest use to which Banalg may be put is in the ordinary rubbing care of injuries. Almost any closed-skin trauma to the foot and leg may be benefitted by the application of massage.

The lightest form of massage, effleurage, provides rhythmic stimuli to the organs of touch. A stronger stroke may produce blanching followed by hyperemia. The blanching phase is possibly caused by the release of a histamine-like substance or from the temporary anoxemia that compression of the area causes. In either case, the hyperemic response comes from a dilatation of the cutaneous blood vessels with an increase in the volume of blood flow.[5]

Massage gives the best results when preceded by exposure to external heat. That's where Banalg comes in. Banalg is applied to traumata by effleurage. After five minutes have elapsed, sensory and reflex nervous response at the injured site carry their impulses to the brain, registering a marked degree of heat. Strong stroking now with Banalg used as a lubricant, acts to directly, mechanically displace fluid in the lymphatic and vascular channels. Toxic or foreign materials are removed from focal lesions by either the increase in circulation or by the influence of the direct pressure. Thus, significant neurovascular activity is induced, terminating in a neuromuscular response.

Clinical Trials with Banalg

Banalg Liniment was the sole rubefacient agent used on 170 people with miscellaneous musculoskeletal foot and leg lesions. These included: ankle sprain, dislocation, post-fracture, stiff joint, arthritis, strained plantar fascia, myalgia, neuralgia and local inflammations.

Ankle sprain: Four cases of ankle sprain were treated bi-weekly with warm whirlpool and superficial stroking of the leg above the ankle, using Banalg. Movements were begun a slight distance from the swelling, working proximally toward it until the whole of the injured area was included. Slight passive movements of the involved joint were attempted as healing progressed. Tape dressings were applied for immobilization between visits. Results were gratifying.

Dislocation: Disrupted articulations including metatarsal, cuboid and cuneiform bones were treated with local heat and manipulation. After gentle reduction of the subluxation, Banalg and ultrasound were utilized to heal torn ligaments or sedate neighboring muscle spasms. Five cases responded well to special care.

Post-fracture: After prolonged immobilization, two cases of fracture of the proximal phalanx of the lesser toes, one involving the third toe and one the fifth toe, responded to Banalg rubbing and infra-red baking.

TABLE I
PROBABLE INFLUENCES OF MASSAGE[6] WITH BANALG

	Primary or Early Effects	Secondary or Late Effects
Vascular system	Release of histamine with acetylcholine Vasodilation	Increased flow Increased red blood cell platelets Sticking of emigrating leukocytes Decreased pooling of blood in splanchnic area Discharge of red cells from spleen
Peripheral lymphatics	Emptying	Decreased trend toward fibrosis
Striated muscle	Stimulation to contraction	Relaxation from spasm
Unstriated muscle	Stimulation to contraction	Discharge of materials
Nervous system Deep nerve trunks	Stimulation	Reflex relaxation
Cutaneous sensory nerves	Stimulation	Relaxation of the psyche
Central nervous system	None	Relief of pain
Connective tissues	Friction between parts	Increased elaboration of lubricating fluid
Joint, synovial fluid	None	Increased rate of removal of particulate materials

Stiff joint: Hallux limitus and associated conditions were treated with splinting, movement, traction, massage and heat. Superficial heat in the form of hot compresses, electric heating pads or hot foot soaks were applied by the patient himself at home. This was followed by massage with Banalg, stroking and kneading the joint area. This was an effective psychological and physiological therapeutic regimen for patients in three cases.

Arthritis: Massage with Banalg afforded significant relief in arthritic feet suffering from neuromuscular disturbances, such as twitching and spasm. Twelve old people, members of the same convalescent hospital,

were given Banalg for daily massage. All agreed that they felt better after its use.

Strained Plantar Fascia: Tired, aching feet of 25 individuals were afforded relief by the periodic use of Banalg massage. A hot epsom salt foot bath followed by brisk massage with the liniment allowed housewives to complete their working day. This same home therapeutic routine, prior to the donning of high-heeled, thin-soled dress shoes, allowed other women to enjoy a social evening without excessive foot fatigue.

Myalgia: Muscle cramps, pains of severe exercise, fatigue aches and associated tendonitis or tenosynovitis responded to Banalg massage, heat and Banalg, ultrasound and Banalg, or medical galvanism in ten cases. Frequently, a Banalg poultice was made use of where a thin piece of cotton felt saturated by the liniment was adhered to a painful muscle area. This kept the rubefacient inscription in constant therapeutic touch with the injured area.

Neuralgia: Deep neuralgia, especially of the Morton's type, which includes the superficial branch of the external plantar nerve[7], does not respond to massage alone. Banalg and ultrasound have some relief-giving qualities, but orthopedic care or surgical intervention will invariably have to be utilized. This was the case in one Morton's neuralgia sufferer. Two other people with vague, superficial tingling and numbness of the tips of the toes were relieved by substituting the alternate cooling and warmth effects of Banalg massage.

Local inflammations: Taylor bunions, slight swellings over hallux valgus and achillodynia were helped by Banalg application. Congestion was relieved and stasis of the blood supply was dissipated by the antiphlogistic action of the medication. This promoted local absorption of the static metabolites. Six people responded well to this kind of treatment and other measures.

Routine Office Measure: At least one hundred pairs of feet were given routine Banalg massage as an integral part of the Podiatry treatment. Following the reduction of excrescences, brisk massage was given, using Banalg as the massage lotion. This was followed by an isopropyl alcohol rinse to eliminate a possible burning feeling afterward. The feet were dried with a terry cloth towel. The psychological effect was so remarkable that this method has become established post-treatment office practice. Banalg gives off a clean, fresh smell and a pleasant tingling sensation to the feet when followed by alcohol and rough drying.

Summary

Banalg Liniment has shown itself to be the ideal rubefacient medication for 170 people. Its pharmaceutical components, consisting of menthol, camphor, methyl salicylate and oil of Eucalyptus, were each discussed. Its use with various physical therapy modalities, including external heat, medical galvanism, ultrasound and massage, were examined. And its clinical application to common foot and leg lesions was shown. By far, its broadest use is with effleurage and especially as a physiologic and psychologic therapeutic agent for post-treatment massage.

1845 Summer St.

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TREATMENT OF ONYCHOMYCOSIS AND DERMATOPHYTOSIS WITH GRISEOFULVIN

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WITHIN two years, since publication of the first clinical reports[1-3] indicating the efficacy of oral griseofulvin against superficial fungous diseases, this drug has become established as the treatment of choice for tinea of the hair, skin and nails.[4-6] Griseofulvin is used in podiatry[7-10] to treat the numerous cases of tinea pedis which are so extensive or chronic that topical therapy is insufficient, and it is the only reliable method of treatment for fungous infections of the toenails. Our experience with this drug is reported below.

Method

Griseofulvin®[1] was used for one to 28 week to treat 17 patients with onychomycosis, 26 patients with dermatophytosis, and two patients with onychomycosis and dermatophytosis. The dosage was 250 mg. four times daily; if therapy was continued for 12 weeks or longer, dosage was reduced to 250 mg. three times daily. The infecting organism was found to be Epidermophyton floccosum in two patients, Trichophyton mentagrophytes in 12, and Trichophyton rubrum in 18; four patients were infected with both T. mentagrophytes and T. rubrum, and nine with both T. mentagrophytes and Candida albicans (Table I).

Cultures were made regularly during the period of treatment with griseofulvin and no patient was considered cured until these were negative. Clinical criteria were used to evaluate improvement as therapy progressed.

In the patients with mixed T. mentagrophytes and C. albicans infections, the latter were treated topically with two per-

cent solution of gentian violet, applied once daily for two weeks, and the patients were instructed to scrub the affected areas twice daily for ten minutes with hexachlorophene soap. All cultures were negative for C. albicans after two to four weeks of this regimen.

Results

Onychomycosis. The patient with onychomycosis due to T. mentagrophytes (with C. albicans) was slightly improved after six weeks of treatment with griseofulvin; the patient with an infection due to E. floccosum was improved after 12 weeks of treatment but did not wish to continue with the drug.

Of the seven patients with T. mentagrophytes infections, six were cured or greatly improved after 12 to 28 weeks of treatment; the other patient discontinued treatment after six weeks. After 24 weeks of treatment, one of these patients complained of fatigue. Analysis of the blood showed moderate anisocytosis and target cells, and the segmented granulocytes showed cytoplasmic granulation. Medication was discontinued and after four weeks the patient's general health was normal.

After 16 to 20 weeks of treatment five of the seven patients with T. rubrum infections were cured or significantly improved. One patient showed slight improvement after eight weeks of therapy and one discontinued the drug after one week of treatment because of a pre-existing peptic ulcer.

The patient with a combined T. mentagrophytes and T. rubrum infection was improved after 16 weeks of treatment but the drug was then discontinued because of a skin reaction.

®[1] Provided as Fulvicin through the courtesy of R. Richard McCormick, M.D., Medical Research Division, Schering Corp., Bloomfield, N. J.

TABLE I

Clinical Diagnosis	Laboratory Diagnosis	No. of Patients	Weeks of Treatment
Onychomycosis	T. mentagrophytes, C. albicans	1	6
Onychomycosis	E. floccosum	1	12
Onychomycosis	T. mentagrophytes	7	6-28
Onychomycosis	T. rubrum	7	1-20
Onychomycosis	T. mentagrophytes, T. rubrum	1	16
Onychomycosis and acute vesicular dermatophytosis	T. mentagrophytes, C. albicans	1	12
Onychomycosis and interdigital dermatophytosis	T. mentagrophytes, C. albicans	1	4
Acute vesicular dermatophytosis	T. mentagrophytes, C. albicans	3	9-10
Acute vesicular dermatophytosis	T. mentagrophytes	4	3-16
Acute vesicular dermatophytosis	T. rubrum	2	4, 4
Acute vesicular dermatophytosis	T. mentagrophytes, T. rubrum	1	8
Chronic hyperkeratotic dermatophytosis	T. mentagrophytes, C. albicans	2	3, 6
Chronic hyperkeratotic dermatophytosis	T. rubrum	2	8, 8
Chronic hyperkeratotic dermatophytosis	T. mentagrophytes T. rubrum	2	4, 20
Interdigital dermatophytosis	T. mentagrophytes, C. albicans	1	8
Interdigital dermatophytosis	E. floccosum	1	3
Interdigital dermatophytosis	T. mentagrophytes	1	4
Interdigital dermatophytosis	T. rubrum	7	3-5

Onychomycosis and Dermatophytosis. The patient with onychomycosis and acute vesicular dermatophytosis due to T. mentagrophytes (with C. albicans) was cured after 12 weeks of treatment. Medication was stopped after four weeks, because of a skin reaction, in the patient with onychomycosis and interdigital dermatophytosis also due to T. mentagrophytes (with C. albicans).

Acute Vesicular Dermatophytosis. The three patients with acute vesicular derma-

tophytosis due to T. mentagrophytes (with C. albicans) were cured after nine or ten weeks of treatment. In one of these patients there was a recurrence ten weeks after discontinuance; resumption of therapy, for three weeks, again cleared the infection.

The four patients whose infections were due to T. mentagrophytes alone were cured or substantially improved after three to 16 weeks of treatment. Both patients with T. rubrum infections were cured after four weeks of treatment.

The patient with a combined T. mentagrophytes and T. rubrum infection was cured after eight weeks. The infection recurred eight weeks after discontinuance but subsided after an additional course of treatment for three weeks.

Chronic Hyperkeratotic Dermatophytosis. The two patients with chronic hyperkeratotic dermatophytosis due to T. mentagrophytes (with C. albicans) were cured after three and six weeks of treatment. One patient with a T. rubrum infection was cured after eight weeks and the other was substantially improved in the same period of time. One of the two patients with a mixed T. rubrum and T. mentagrophytes infection was cured after four weeks; the other showed no improvement after 20 weeks of treatment and a systemic glandular complication was suspected.

Interdigital Dermatophytosis. Three patients with interdigital dermatophytosis due to T. mentagrophytes (with C. albicans), E. floccosum, and T. mentagrophytes, respectively, were cured after eight, three, and four weeks of treatment with griseofulvin. The seven patients in whom T. rubrum was the infecting organism were cured after three to five weeks of treatment.

Summary and Conclusion

Griseofulvin (Fulvicin) was used for up to 28 weeks to treat 45 patients with onychomycosis or dermatophytosis or both. The infecting organisms, which occasionally occurred in combination, were Candida albicans, Epidermophyton floccosum, Trichophyton mentagrophytes, and T. rubrum.

Cure or major improvement was observed in 38 patients (84 percent). Infections of the skin usually could be cleared within one month; when the nail was infected, several months of treatment were required before most of the nails were clinically normal. Two of these patients (one with a mixed T. mentagrophytes and C. albicans infection, the other with a mixed T. mentagrophytes and T. rubrum infection) had recurrences approximately two months after discontinuance of the drug but the infections were cleared again after three weeks of readministration of griseofulvin. There did not appear to be any significant correlation between the type of infecting organism and the time required for cure.

A patient with T. mentagrophytes (with C. albicans) and another with T. rubrum were slightly improved by griseofulvin. It is possible that longer periods of therapy would have produced better results in these patients. One patient with a mixed T. mentagrophytes and T. rubrum infection showed no improvement after a sufficient period of therapy and a systemic glandular component is suspected. The remaining four patients discontinued the drug prematurely.

Two patients had a skin reaction to griseofulvin. A third patient, who had been treated for approximately six months, complained of fatigue. Blood studies indicated a possible toxic reaction which disappeared after the drug was discontinued.

121 Sycamore St., N. E.

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CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

HEMANGIOPERICYTOMA
A Case Report

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MALE patient, white, age 56, presented himself at the writer's office complaining of a painless enlargement, subcutaneous, in the web of the first cleft of the right foot.

Examination: A dense mass was palpable beneath the skin of the web of the 1st and 2nd toes. There were several nodules on the skin, directly overlying the growth. The mass seemed firmly adhered to the skin and the deeper structures.

History: Two and one-half years prior, the author excised an extremely painful growth from the skin in the same area. A microscopic report of the specimen was a "glomus tumor." Healing was uneventful and no trouble was experienced until two weeks before this last visit. The patient claimed that not until that time did he notice the mass. Since there was no pain, he could not be certain as to how long it had actually been present.

Treatment: It was decided to excise the growth and the patient was admitted to the hospital. The entire web, including the nodules, was removed with the growth. The mass, which was pale brown in color, was attached by many tough fibrous bands to the surrounding structures and extended, posteriorly, to the corresponding metatarsophalangeal joints. The growth measured 3 x 2 x 1½ cm. The microscopic report was "malignant hemangiopericytoma." This report was reviewed by two other laboratories who agreed with the diagnosis.

The patient was then referred to the Tumor Clinic of the City of Syracuse and it was decided that, in view of the malignant nature of the growth, a partial amputation of the foot was in order. Consequently, the 1st and 2nd toes were removed, as were the corresponding heads of the metatarsal bones. The final pathologic report of the amputated tissue showed that it contained a few small areas of residual tumor in the first web space which were

again described as "hemangiopericytoma."

The patient made a complete recovery and has since returned to his usual occupation of milk delivery.

Comment: A hemangiopericytoma is a relatively rare tumor of varying degrees of malignancy. It is basically vascular in nature, occurring mostly in the superficial soft tissues, chiefly the subcutaneous and muscular layers. Microscopically, it is observed that the cells grow from the outside of the capillary sheaths. It usually makes its appearance in the middle-aged, but has been noted, occasionally, in the new-born and in the aged. The tumor can metastasize and several cases have been known to terminate fatally, usually when the growth was originally located near some vital organ.

2300 James St.

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AINHUM-DACTYLOLYSIS SPONTANEA

A Case Report

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AINHUM-dactylolysis spontanea is a condition occurring chiefly in Negroes in tropical countries marked by linear constriction of the toe, especially the little one where the constriction causes a gradual amputation of the toe.

This condition is one that is rarely seen in the United States and is reported here to reacquaint the practitioner of the possibility of this condition. Ainhum is not characterized by pain; however, the case described below is atypical in that pain of the fifth toe was the patient's chief complaint.

This patient has never been out of the country, nor to my knowledge ever had any intimate contact with anyone who has.

Mrs. A. H., age 43, Negro, presented herself to my office on March 21, 1960, with a complaint of pain in her fifth toe, right foot. Physical examination of the area of complaint revealed a constricture (such as seen upon the removal of a tight ring from a finger) at the base of the fifth toe, with granulation tissue present in the web. She had been treated by local medical doctors but to no avail. The granulation tissue healed with routine care within the period of one week; however, pain was still present. A diagnosis of Ainhum was tentatively made. On July 25, 1960, the patient's toe was amputated and lab section confirmed the diagnosis.

718 Court St.

" . . . the family is still the one social relationship which can give the human person a sense of the complete life in the presence of today's fragmented experience; it alone can endeavor to sift out of new conflicting values a set of norms and principles that can be reliable guideposts on our human journey."

Rev. Lawrence J. McGinley,
President, Fordham University

THE HOSPITAL—ITS RESPONSIBILITIES AND OPPORTUNITIES*

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HISTORICALLY, the hospital as we know it, is a young institution. Although the sick, especially those believed to have communicable diseases (unclean—in the Biblical sense) had been isolated or segregated from before historical times, their confinement was a means of protecting the undefiled rather than a method of helping the afflicted. Christian charity established almshouses and asylums for the destitute, homeless and aged, but the sick who had private means were treated at home rather than in institutions until very recent time. It is most appropriate to point out at the dedication of this unique hospital for the care of the foot, that the modern hospital of the Western World is descended directly from refuges for relief of the footsore and weary. While there are many lines of historical derivation—from ancient temples of Saturn, from shrines dedicated to Imhotep in Egypt and Esculapius in Greece, the term hospital and the institution of today derives particularly from the wayside lodges where weary travelers rested during their pilgrimages to the Holy Land during the Age of Faith. Some of the hospitals established in the eleventh to fourteenth centuries are still in existence. While their role has changed with the development of scientific medicine, the stone walls have remainced the same.

The hospital of the era of the Crusades was not concerned principally with the sick. Among the footsore, however, there were the homeless and disspirited or ill, lodgers who required more than a bed and a bath for tired feet. Nursing care was their first demand. Financial support from the religious orders and nursing services administered by sisters and monks established the pattern for the medieval hospitals devoted to the care of the sick and disabled.

The policy of institutional care for the indigent which still prevails in our public hospitals governed most hospitals until recent times. For centuries, the hospital was a very poor place in which to anticipate recovery of health. It was rather a place where those who could not otherwise receive attention were segregated for medical care and spiritual preparation for the hereafter. As such, these institutions became centers for the concentration of pestilence. Sanitation did not exist. Little could be offered by way of diagnosis or treatment. The hospital bred its own diseases (as indeed it still does). Hospital gangrene and infection were the dread of the wounded and the sick. Communicable diseases often spread through the hospitals unchecked. As late as 1788 the death rate among patients in the venerable Hotel Dieu of Paris was 25% and that of surgeons and staff from 6 to 12% annually. Descriptions of military hospitals during the American Civil War and the Crimean War convey the horror of the period just before the birth of modern bacteriology and sanitation.

Only within the past few decades has the hospital become a place in which there was a consistently better chance to regain health than to die. One of the first great attacks on hospital filth and efficiency was the heroic work of Florence Nightingale. With a staff of 38 nurses she arrived at Scutari, in the Crimea, on the eve of a great battle on November 4, 1854. Her mission was to remedy the abominable conditions of the field hospitals and her authority from the British Secretary of War was sufficient to

*Address at dedication of California Podiatry Hospital, San Francisco, California, Saturday, April 30, 1960.

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overcome the apathy and red tape of the military. The death rate in the army hospitals was 42 per cent in February 1855; in June it had been reduced to 2 per cent by the introduction of humane methods and rudimentary sanitary practices. From her subsequent efforts in England grew the first schools of nursing which made modern hospital practice possible. The character of hospital care was revolutionized when the sciences of bacteriology, chemistry and pharmacology began to open the way toward modern medical and surgical practice.

At present, the hospital is an institution where the marvels of science and technology bring relief to the sick and injured, restore the infirm, revise and correct nature's errors, bring the newborn into the world with safety for mother and child, and generally advance the health of the population. Hospitals serve as teaching centers for physicians, nurses, therapists, social workers, technicians and the general public as well. In fact, the time has come when the variety of technics known, the scope of knowledge in biology, psychology and sociology, as well as medicine, makes it possible for the hospital to be a true temple of learning and source of unadulterated benefit to suffering mankind. From an institution which often contributed to man's suffering in the past and served all too frequently as an unsavory station between suffering on earth and a hopefully peaceful hereafter, it has changed to a place which has the potentiality for tremendous improvement of the life of mankind.

What then, are the modern hospital's responsibilities? The primary responsibility is to serve the patient who entrusts his care to its staff. The hospital must assure the basic comforts, conveniences and services required by current standards, and it must do much more than this. It must provide an environment which is therapeutic and beneficial. It must not only follow Hippocrates' admonition to physicians, at least to do no harm; it must make every possible contribution to health. To meet these simple criteria may seem quite easy, yet constant critical and impartial evaluation and improvement are necessary to determine that they are truly met.

An additional responsibility is the provision of the essentials for advancement of clinical practice. These are physical facilities for diagnosis and treatment, well-staffed laboratories and, in addition, well-planned programs in research and education, preferably in conjunction with a professional school.

Administratively, methods must be developed for review and critical appraisal of all aspects of clinical practice. Communication must assure that all levels of staff are familiar with operation of the hospital. Educational activities, starting with indoctrination of new staff—prior to assignment to duty—should be continuous throughout the year.

A new hospital will necessarily have a period of growing pains and uncertainty. Mistakes will be made, petty grievances and political difficulties will undoubtedly arise. There will be conflicts between the more idealistic and the more necessary practitioners who use any hospital's facilities. Unnecessary surgery and prolonged hospitalization will have to guarded against, in order that no abuses may occur. The threat of hospital infection of the modern variety will complicate the routine of surgical care and convalescence. The ubiquitous staphylococcus will make its debut unless meticulous precautions are taken from the start to maintain the highest possible level of sanitation. In addition to all these potential and obvious difficulties there will be other threats to the quality of patient care.

To be specific and very outspoken, there will be great danger that the methods and traditions of general hospitals will be too readily accepted by a professional group

which is having its first experience with a hospital of its own. There will, no doubt, be a tendency to impose the restrictions on patients which have prevailed in hospitals for generations. Sometime in the remote past, physicians concluded that bed rest was an essential part of all hospital care. This was doubtlessly based, in part, upon the erroneous idea that people recover strength as a result of rest. It was also fostered by recognition of the relative simplicity of operation of hospitals when people were well confined to specific places. Patients in bed did not get lost, nor did they get in the way of attendants. Eventually the confined and restricted patients, no matter how irritable and ambitious they might be at first, developed into "good patients" and everyone was satisfied to minister to them as efficiently and quickly as possible. Visiting hours were limited because the visitors got in the way of the attendants and threatened the routine of the hospital. Recreation in hospitals is a relatively modern idea, even today offered in only few institutions, and rarely adequate to overcome the bad influences of rest and inactivity. As a consequence, the hospital has become a place where long confinement is almost always deteriorative and other- than restorative. Fortunately, the advent of modern surgical methods and effective drugs has limited the duration of hospital stay for most people. However, skeletal difficulties and physical handicaps may require long periods of care and in these instances it is likely that the hospital may turn out to be more damaging than helpful, unless great precautions are taken.

It would be interesting to try to trace the development of the bare and unfriendly hospital room. Possibly, before the day of Lister when antisepsis was introduced, some hospital rooms were pleasantly decorated and uplifting. Certainly, in many Oriental hospitals there is a greater interest in decor than in our own. The modern hospital, with its orderly routine, its antiseptic interior and prison-like exterior, is not necessarily a place where people are stimulated to feel better or get well. Traditional nursing care, built around bed rest and inactivity, often complicates illness by the effects of disuse. Muscles, when unused, become wasted. Bones which are not moved and acted upon by muscles, tend to lose their substance and especially their lime salts. Increased excretion of lime salts has a dangerous potential for forming kidney and bladder stones. Immobility of joints and muscles causes contractures and deformity. Undue rest and social isolation tend to dull the mind and blunt the personality. These dangers prevail especially in hospitals for the chronically ill, but all of the disuse effects mentioned have their beginnings during acute care and can be counteracted only by assiduous attention to the principles of good physical and psychological patient care.

One can but hope that a group of specialists with sufficient imagination to establish a hospital dedicated to the human foot —that neglected and martyred member of the body of man—will have the courage, intelligence and foresight to recognize their opportunities to establish new precedents. This compact institution is a place where friendliness and good rapport can give patients a sense of participation in recovery. The introduction of color and the addition of decorative art will make for convalescence in an atmosphere which is cheerful and therapeutic. New knowledge of human relations and understanding of patient needs can make this a hospital where there will be less nursing administered and more self-care stimulated; where men and women will retain their dignity, preserve their self-image and be stimulated to regain their independence and health.

Because you will be dealing principally with the foot, it will not be easy to achieve early ambulation in every instance. How-

ever, the majority of patients will have one uninvolved foot and this is enough to permit their early mobility with crutches. Those with bilateral foot involvement will prove a challenge for the invention of new methods of ambulation which will avoid the hazards of prolonged rest. Aside from the problems of ambulation and activity which are inherent in the care of the foot, it is important to deal with every person as an individual—not merely as the incidental adjunct to a pedal apparatus in need of repair.

Many persons who have suffered the distressing discomfort of foot pain and displeasure of foot deformity will be made to walk again in comfort and joy, because of the care they receive here. If they can experience relief from pain and improvement of function under circumstances which will leave them with pleasant memories of hospitalization, the future of this institution will be assured and its success will be a cause for great satisfaction to all who work within its walls.

2380 Ellsworth St.

HOSPITAL PODIATRY SERVICE

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MANY podiatrists wish to serve on hospital podiatry staffs. Many of them are not aware of how to proceed, or know what is expected of them, and are even unsure of what to expect for themselves. Perhaps these few thoughts arising from personal experience may be helpful.

Initial Approach for Podiatrists to Obtain Hospital Affiliation

Initial approach to hospital staffing of podiatrists is based on individual contacts, qualifications, references and classification of the hospital. The way has been opened by pioneers in our profession in many of our states. Many state and locally sponsored hospitals supported by the taxpayer now realize the importance of a well-balanced integrated departmentalized podiatry staff.

We will first consider state and county institutions. Where legislation provides for the establishment of podiatry clinics by the administrative heads, we should approach the hospital administrator directly. A personal interview should be arranged with the hospital administrator to explain how we in our profession fit into his program for better health for our community. At this interview we should be armed with statistical facts and references, such as *"Hospital Organization and Management,"* by Malcolm T. MacEachern, M.D., 1959 Edition; *"The Role of the Chiropodists in Hospitals,"* by Dr. Forman, June 1957, *"Hospital Management."* The podiatrist should present a college catalog, showing the educational background of the profession, our scope of practice and, in a straightforward, sincere manner, show how a podiatry clinic would aid in benefiting the hospital in producing an added health program. It is my belief that the podiatrist should attempt to compare our professional contribution to the institution to dentistry, stressing the fact that our services and specialized technics in preventive medicine related to the foot add considerably to the established methods of medicine and its specialties.

Our service in preventive foot care, acute and chronic manifestations of the foot and rehabilitation of the foot serves a major need to the patient, thus aiding the health program of the community.

Private endowed hospitals are usually approached on a personal basis. Large privately endowed hospitals with outpatient

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clinics can best be approached through their diabetic department. The reason for this is the expressed attitude of such leaders in diabetes as Drs. Joslin, Wilder, and others, as regards the foot care needs of the diabetic patient. Many foot and leg amputations have been caused by improper foot care.

In smaller privately endowed (proprietary) hospitals, the approach is primarily through personal association with the powers that be, who usually are well-informed as to our background, our training and our responsibilities as a professional man.

What Is Expected of a Podiatrist In a Hospital

A hospital is a massive departmentalized institution in which each cog must fit well and move smoothly. Thus a podiatrist in a hospital should be able to diagnose foot conditions, treat those conditions that come within the established scope of his clinical limitations, have the ability to differentiate and refer to other departments that which are not directly in his category, and aid in establishing interprofessional relationship between his profession and the others. For example, a new patient should be examined thoroughly, after studying the past history work-up that accompanies the patient. Systemically, the patient's problem usually is taken care of by the internist. Local manifestations of the foot are the podiatrist's domain.

Since a departmentalized approach to a patient may encompass many various clinical visits ranging from dermatology on through to orthopedics and surgery, good liaison must be established throughout the hospital. It is expected of a podiatrist in a hospital that he attend staff and conference meetings of the general body and of those specialties that interlace within his profession.

A podiatrist in a hospital is given that rare privilege of free postgraduate training as well as representing his profession to medicine at large. This privilege affords him the opportunity to further podiatry and the profession expects him to represent it well.

The podiatrist is expected to practice every facet of his profession according to state practice acts. He must do general podiatry, understand X-ray interpretations, do foot rehabilitation, practice prophylactic foot care and preventive medicine in relation to the foot. He must be an instructor in his profession to the other departments. As a public relations representative, he must show them what a podiatrist is, and inform them as to the scope of his profession.

What Can a Podiatrist Expect from a Hospital Affiliation?

A podiatrist can expect from a hospital that which he unselfishly and dedicatedly does for his profession in the hospital. One does not measure return when giving of one's services. However, Emerson's "Law of Compensation" holds true here as well as in any other ideology of living. A podiatrist can expect prestige among the professional peoples, the use of all the hospital's armamentarium, libraries, literature, postgraduate work, clinical evaluation and experimentation and research. From a personal standpoint, social and professional contacts help create a better rounded practice. Personal gains do sometimes come about through staff privileges in other hospitals.

Podiatry Staffs Versus One-Man Operations

Wherever a staff is possible, learning is greater and patient care is more diversified. It is the author's opinion, having served both as a one-man operation, and as a podiatry staff affiliate, that greater recognition is obtained through a podiatry staff status. Monthly meetings of staffs, interdepartmental staff meetings, etc., make for a more stimulating hospital association.

6135 Wilshire Blvd.

A REPORT OF THE STATISTICAL SURVEY

Council on Professional Information
B. C. Egerter, Chairman
Statistical Survey Committee

In July 1956, questionnaires were sent to all chiropodists practicing in the states of California, Iowa, Pennsylvania, Texas and the District of Columbia. Each of these questionnaires was accompanied by a letter explaining in detail the purpose of this pilot study and asking for the cooperation of the chiropodists. The Council on Professional Information was greatly encouraged by the high percentage of returns for this type of study and by the many who took time to indicate in the section for remarks that there was a need for such a study and made helpful suggestions. (See "Pilot Economic Survey," Journal, National Association of Chiropodists, Vol. 17, July 1957.)

Through the knowledge gained from this pilot survey, the Council on Professional Information compiled a very broad and inclusive questionnaire, and sent it to every chiropodist-podiatrist in the United States, totaling 8,200. The questionnaire was a lengthy one—58 questions with some having as many as 14 separate parts.

The Service Bureau Corporation (IBM Subsidiary), who acted as advisors in this study and tabulated the questionnaires, informed the Council in the very beginning that an eighteen per cent (18%) response from this type of survey was considered excellent. Due to the length of the questionnaire and the amount of detail information required, the Bureau indicated that the percentage in our case would be considerably less.

Three thousand, two hundred ninety-six (3,296) questionnaires were received by the Service Bureau Corporation, making a 40.19 percentage return on the complete mailing. This represents an all-time high percentage for this type of study and definitely can be considered as a compliment to the profession.

The following are tabulations of the responses to the questions. After each question is the number of individuals who failed to respond to the particular question. (All responded to question one.)

1. In Which State Is Your Practice Located? .....

Alabama	7	Nebraska	19
Alaska	0	Nevada	3
Arizona	7	New Hampshire	13
Arkansas	7	New Jersey	177
California	304	New Mexico	9
Colorado	28	New York	610
Connecticut	108	North Carolina	30
Delaware	13	North Dakota	5
District of Columbia	35	Ohio	236
Florida	85	Oklahoma	19
Georgia	16	Oregon	17
Idaho	13	Pennsylvania	351
Illinois	271	Rhode Island	22
Indiana	65	South Carolina	4
Iowa	44	South Dakota	6
Kansas	21	Tennessee	7
Kentucky	33	Texas	72
Louisiana	13	Utah	14
Maine	9	Vermont	4
Maryland	27	Virginia	24
Massachusetts	175	Washington	33
Michigan	140	West Virginia	17
Minnesota	46	Wisconsin	78
Mississippi	3	Wyoming	6
Missouri	40		
Montana	10		3,296

2. Age (check one) 10

☐ 21-29	272	☐ 45-49	542
☐ 30-34	484	☐ 50-54	409
☐ 35-39	602	☐ 55-60	206
☐ 40-44	534	☐ Over 60	237

3. Sex (check one) 75

☐ Male	3,107	☐ Female	114

4. Race (check one) 105

☐ Caucasian	3,027	☐ Oriental	6
☐ Negro	83	☐ Other	75

5. From Which Podiatry-Chiropody College Did You Graduate? (check one) 30

☐ California	244	☐ Ohio	683
☐ Chicago	305	☐ Temple	482
☐ Illinois	701	☐ Other	122
☐ New York	730		

6. Highest Degree Earned (check one) 31

☐ D.S.C.	2,498	☐ Pod.G.	38
☐ Pod.D.	647	☐ D.S.P.	14
☐ M.Cp.	26	☐ Other	18
☐ G.Cp.	26		

7. Length of Professional Course (check one) 30

☐ 1 year or under	78		
☐ 2 years	537	Other	1
☐ 3 years	791		
☐ 4 years	1,570		
☐ Over 4 years	289		

8. Years of Pre-Professional College Education (check one) 103

☐ 1 year	699	☐ 4 years	430
☐ 2 years	835	☐ Over 4 years	157
☐ 3 years	333	☐ No College	739

9. Highest Non-Professional Degree Earned (check one) 488

☐ A.A.	70	☐ Ph.D.	4
☐ B.A.	201	☐ Pharmacy	53
☐ B.S.	318	☐ Other	83
☐ M.A. or M.S.	24	☐ None	2,055

10. Number Years in Practice (check one) 47

☐ Under 5	505	☐ 21-30	915
☐ 6-10	853	☐ Over 30	297
☐ 11-20	679		

11. How Did You First Establish Practice? (check one) 13

☐ Not in Private Practice	34
☐ Purchased Practice	310
☐ As an Associate	351
☐ Individually	2,588

12. Population of City or Town in Which You Practice (check one) 37

☐ Under 10,000	197	☐ 51,000-100,000	431
☐ 11,000-20,000	386	☐ 101,000-250,000	375
☐ 21,000-30,000	246	☐ 251,000-500,000	213
☐ 31,000-50,000	392	☐ Over 500,000	1,019

13. How Many Podiatrists-Chiropodists Practice in Your General Area? (check one) 50

☐ 1-10	1,883	☐ 41-60	86
☐ 11-25	629	☐ 61-100	100
☐ 26-40	232	☐ Over 100	316

14. Are You Now a Member of the A.P.A.-N.A.C.? (check one) 38

☐ Yes	2,715	☐ No	543

15. Office Location (check one) 61

☐ Residential Section	1,027
☐ Downtown	1,634
☐ Suburban Shopping Center	360
☐ Other (specify)	214

16. Office Type (check one) 76

☐ Professional Building Share Reception Room	334
☐ Professional Building Do Not Share Reception Room	1,088
☐ Medical Center	116
☐ Home	529
☐ Ground Floor Business Section	676
☐ Walk-up Business Section	477

17. Hours Spent Per Week in Auxiliary Office (check one) (Check "Zero" If You Have No Auxiliary Office) 104

☐ 0	2,650	☐ 11-20	103
☐ 1-10	384	☐ Over 20	55

18. Hours Spent in Main or Only Office (check one) 39

☐ Under 20	101	☐ 41-50	1,296
☐ 21-30	295	☐ Over 50	236
☐ 31-40	1,329		

19. Days Off Per Week (Not Including Sundays and Holidays) (Check one) 31

☐ None	329
☐ ½ day	746
☐ 1 day	1,442
☐ 1½ days	549
☐ More than 1½ days	199

20. How Many Evenings Per Week Do You Have Office Hours? (check one) 22

☐ None	1,474	☐ 3	310
☐ 1	491	☐ More than 3	304
☐ 2	695		

21. Average Number House Calls Per Month (check one) 32

☐ 0	403	☐ 26-50	59
☐ 1-10	2,462	☐ Over 50	16
☐ 11-25	326		

22. In Which of the Following Do You Serve Professionally? (check all those applicable) 187

☐ No institution connection	1,101
☐ Hospital surgical service	615
☐ Other hospital service	591
☐ Nursing home	981
☐ Home for the aged	895
☐ Industrial clinic	27
☐ Labor union health service	36
☐ City or State institution or hospital	289
☐ Public school health service	63
☐ Parochial school health service	55
☐ Trainer or consultant for teams or events	183
☐ Other (specify)	143

23. Average Number Hospital or Institutional Calls Per Month (check one) 114

☐ 0	1,081	☐ 26-50	68
☐ 1-10	1,756	☐ Over 50	50
☐ 11-25	227		

24. How Many Days Per Month Do You Devote to Hospital or Institutional Service? (check one) 135

☐ None	1,779	☐ 6-10 days	129
☐ 1 day	446	☐ Over 10 days	76
☐ 2-5 days	731		

25. What Is The Average Number of Office Treatments You Give Per Week? (check one) 60

☐ 25 or less	353	☐ 101-150	373
☐ 26-50	1,086	☐ 151-250	66
☐ 51-100	1,351	☐ Over 250	7

26. How Many Different Patients Did You Treat in the Past Year? (check one) (Note: Many patients will be treated several times in one year. The information refers only to the number of different patients, not the number of treatments.) 274

☐ Under 200	443	☐ 1,101-1,500	276
☐ 201-500	1,088	☐ 1,501-2,000	170
☐ 501-800	545	☐ Over 2,000	168
☐ 801-1,100	412		

27. Approximately what Percentage of Patients in Question 26 are Male? (check one) 115

☐ Under 10%	471	☐ 21-33 1/3%	1,177
☐ 11-20%	1,232	☐ Over 33 1/3%	301

28. Approximately what Percentage of All Patients in Question 26 are Children (16 years of age or under)? (check one) 97

☐ Under 10%	1,997	☐ 21-33 1/3%	215
☐ 11-20%	947	☐ Over 33 1/3%	40

29. Average Number of New Patients Admitted to the Practice Per Month (check one) 130

☐ Under 5	138	☐ 21-35	890
☐ 6-10	617	☐ 36-50	281
☐ 11-20	1128	☐ Over 50	112

30. What Is the Source of Referral of Your New Patients? (check your estimates of percentage of referrals from each category)

a. Present Patients (check one) 100

☐ Under 10%	156
☐ 11-20%	276
☐ 21-30%	297
☐ 31-40%	283
☐ 41-50%	493
☐ 51-75%	716
☐ Over 75%	976

b. Drug Stores (check one) 409

☐ Under 10%	2,696
☐ 11-20%	156
☐ 21-35%	25
☐ 36-50%	5
☐ Over 50%	5

c. M.D.'s (check one) 161

☐ Under 10%	2,543
☐ 11-20%	423
☐ 21-35%	116
☐ 36-50%	35
☐ Over 50%	18

d. Telephone Book (check one) 249

☐ Under 10%	1,917
☐ 11-20%	640
☐ 21-35%	288
☐ 36-50%	137
☐ Over 50%	65

e. Drop-ins (check one) 156

☐ Under 10%	2,582
☐ 11-20%	402
☐ 21-35%	108
☐ 36-50%	27
☐ Over 50%	21

f. Others (check one) 975

☐ Under 10%	1,940
☐ 11-20%	250
☐ 21-35%	84
☐ 36-50%	31
☐ Over 50%	16

31. Average Number X-Rays Taken Per Month (check one) 57

☐ None	484	☐ 21-35	213
☐ 1-5	985	☐ 36-50	46
☐ 6-10	871	☐ Over 50	23
☐ 11-20	617		

32. How Many Prescriptions (Drug) Do You Write Per Week? (check one) 69

☐ None	265	☐ 11-20	511
☐ 1-5	1,284	☐ Over 20	303
☐ 6-10	864		

33. How Many Prescriptions (Drug) Do You Dispense Per Week? (check one) 109

☐ None	1,683	☐ 11-20	149
☐ 1-5	909	☐ Over 20	102
☐ 6-10	344		

34. How Many Times Per Week Do You Dispense, Prescribe or Recommend Elastic Hosiery? (check one) 60

☐ None	1,150	☐ 4-5	249
☐ 1	992	☐ 6-9	60
☐ 2-3	700	☐ 10 or more	86

35. How Many Shoe Prescriptions Do You Write Per Week? (check one) 50

☐ None	794	☐ 6-10	490
☐ 1-2	953	☐ 11-20	172
☐ 3-5	742	☐ Over 20	96

36. How Many Times Per Week Do You Administer, Dispense or Prescribe the following? (check one in each category)

a. Local Anesthetics 92

☐ None	632	☐ None	594
☐ 1-5	1,841	☐ 1-5	1,826
☐ 6-13	487	☐ 6-13	366
☐ 14-20	136	☐ 14-20	113
☐ Over 20	108	☐ Over 20	77

b. Antibiotics 320

c. Corticosteroids 158

☐ None	1,357	☐ None	370
☐ 1-5	1,474	☐ 1-10	2,113
☐ 6-13	199	☐ 11-20	448
☐ 14-20	66	☐ 21-30	131
☐ Over 20	42	☐ Over 30	180

d. Foot Powders 54

e. Narcotics, Barbiturates or other Sedatives or Tranquilizers 97

☐ None	1,430	☐ None	1,028
☐ 1-5	1,520	☐ 1-5	1,756
☐ 6-13	178	☐ 6-13	296
☐ 14-20	53	☐ 14-20	100
☐ Over 20	18	☐ Over 20	35

f. Vitamins or Other Nutritional Supplements 81

g. Peripheral Vascular Dilators 110

☐ None	1,484	☐ None	236
☐ 1-5	1,504	☐ 1-10	2,095
☐ 6-13	148	☐ 11-20	758
☐ 14-20	37	☐ 21-30	160
☐ Over 20	13	☐ Over 30	189

h. Emollients, Lotions or Creams 58

i. Other Pharmaceutical Products 229

☐ None	347	☐ 14-20	137
☐ 1-5	1,944	☐ Over 20	132
☐ 6-13	507		

37. How Many Custom-made, Molded, Contour or Similar Shoes Do You Dispense Per Month? (check one) 85

☐ None	2,158	☐ 7-10	54
☐ 1-3	826	☐ 11-15	17
☐ 4-6	137	☐ Over 15	19

38. What Was Your Gross Income This Past Year? (check one) 86

☐ $ 5,000 or under	435
☐ $ 5,000 to $10,000	905
☐ $10,000 to $15,000	883
☐ $15,000 to $25,000	729
☐ $25,000 to $35,000	195
☐ $35,000 to $45,000	40
☐ $45,000 to $55,000	15
☐ Over $55,000	8

39. What Was Your Approximate Operating Cost Last Year? (check one) 79

☐ $ 5,000 or under	2,171
☐ $ 5,000 to $10,000	796
☐ $10,000 to $15,000	204
☐ $15,000 to $20,000	30
☐ $20,000 to $25,000	12
☐ Over $25,000	4

40. What Percentage of Your Operating Cost Is Office Rent? (check one) 143

☐ Under 10%	1,351
☐ 16-20%	1,079
☐ Over 20%	723

41. What Is The Average Amount Spent on Pharmaceuticals Used in the Office Per Month? (check one) 85

☐ Under $25	1,808	☐ $101-200	81
☐ $25-50	1,067	☐ Over $200	18
☐ $51-100	237		

42. What Is the Average Amount Spent on Surgical Supplies Per Month? (check one) (Note: All material with exception of drugs used in rendering professional service.) 104

☐ Under $50	2,057	☐ $200-350	44
☐ $51-100	897	☐ Over $350	18
☐ $100-200	176		

43. How Much of the Amount Spent for Surgical Supplies Indicated in Question 42 Was for Adhesive-Backed Material Per Month? (check one) 116

☐ Under $10	1,252	☐ $101-150	15
☐ $11-25	1,412	☐ $151-250	8
☐ $26-50	404	☐ Over $250	7
☐ $51-100	82		

44. What Was Your Income from Surgery Last Year? (check one) 76

☐ None	933
☐ Under $500	1,163
☐ $ 501 to $ 1,000	481
☐ $1,000 to $ 2,500	332
☐ $2,501 to $ 5,000	199
☐ $5,001 to $10,000	80
☐ Over $10,000	32

45. What Was Your Income from Appliances, Devices, Prosthetics Last Year? (check one) 86

☐ None	177
☐ Under $500	1,179
☐ $ 501 to $ 1,000	759
☐ $1,000 to $ 2,500	567
☐ $2,501 to $ 5,000	338
☐ $5,001 to $10,000	173
☐ Over $10,000	17

46. What Is the Present Approximate Value of Your Professional Equipment? (check one) 47

☐ Under $2,000	632
☐ $ 2,001-$ 4,000	1,277
☐ $ 4,001-$ 6,000	782
☐ $ 6,001-$10,000	416
☐ $10,001-$15,000	98
☐ Over $15,000	44

47. What Is the Average Age of Your Professional Equipment? (check one) 32

☐ Under 5 years	710	☐ 16-20	306
☐ 6-10	1,418	☐ Over 20	250
☐ 11-15	580		

48. What Is the Approximate Value of the Non-Technical Furnishings in your Office such as Reception Room Furniture, etc.? (check one) 55

☐ Under $500	1,590	☐ $2,001-$5,000	100
☐ $ 501-$1,000	1,155	☐ $5,001-$10,000	10
☐ $1,001-$2,000	384	☐ Over $10,000	2

49. What Is the Average Age of the Non-Technical Furnishings, such as Reception Room Furniture, etc.? (check one) 51

☐ Under 5 years	1,229	☐ 16-20	141
☐ 6-10	1,406	☐ Over 20	89
☐ 11-15	380		

50. How Many Podiatrists-Chiropodists are Associates of Yours? (check one) 58

☐ None	2,846	☐ 3	22
☐ 1	265	☐ more than 3	70
☐ 2	35		

51. Weekly Earnings of Associate (Average for all associates if you have more than one) (check one) 342

☐ No Associate	2,622	☐ $201-300	79
☐ Under $100	73	☐ Over $300	50
☐ $101-200	130		

52. Number of Office Assistants Other Than Associates (check one) 73

☐ None	1,771	☐ 3	24
☐ 1	1,214	☐ 4	8
☐ 2	200	☐ more than 4	6

53. Weekly Salary of Assistant (Average of all assistants if you have more than one (check one) 184

☐ No Assistant	1,698	☐ $61-75	178
☐ Under $50	777	☐ Over $75	64
☐ $51-60	395		

54. How Many Treatment Rooms Do You Have? (check one) 33

☐ 1	697	☐ 4	254
☐ 2	1,360	☐ 5 or more	172
☐ 3	780		

55. Indicate How Many of Each of the Following Equipment You Have.

a. Standard Chair? 32

☐ None	56	☐ 4	123
☐ 1	1,139	☐ 5	37
☐ 2	1,457	☐ more than 5	23
☐ 3	429		

b. X-Ray? 37

☐ None	631	☐ 2 or more	97
☐ 1	2,531		

c. Whirlpool? 61

☐ None	894	☐ 3	58
☐ 1	1,883	☐ 4 or more	19
☐ 2	381		

d. Paraffin Bath? 272

☐ None	2,752	☐ 2 or more	31
☐ 1	241		

e. Ultrasonic Machine? 172

☐ None	1,729	☐ 2 or more	35
☐ 1	1,360		

f. Diathermy? 191

☐ None	1,784	☐ 2	97
☐ 1	1,196	☐ 3 or more	28

g. Ultra-Violet? 230

☐ None	1,856	☐ 2 or more	64
☐ 1	1,146		

h. Low Voltage Apparatus? 146

☐ None	1,007	☐ 2	311
☐ 1	1,712	☐ 3 or more	120

i. Oscillator Percussor? 263

☐ None	1,703	☐ 2	220
☐ 1	1,011	☐ 3 or more	98

56. In Which of the Following Community Services Do You Participate? (check all those applicable) 147

☐ None	1,072
☐ Health committee of civic, service or fraternal organization	857
☐ Boy Scouts or Girl Scouts or similar	598
☐ Red Cross	260
☐ Civil Defense	344
☐ Interorganizational care of aged	204
☐ Interorganizational youth fitness	139
☐ Health Council and/or Health Careers	117
☐ Armed Forces Reserve	138
☐ Appointed or Elected to Municipal or State Office	145
☐ Teacher-parent groups	681
☐ Others (specify)	492

57. How Many Post Graduate Courses and Conventions Did You Attend Last Year? (check one) 37

☐ None	653	☐ 3-5	734
☐ 1	849	☐ 6-10	82
☐ 2	926	☐ Over 10	16

58. In Addition to Time Out for Conventions and PG Courses, How Much Vacation Time Did You Take Last Year? (check one) 70

☐ None	499	☐ 4 weeks	452
☐ 1 week	803	☐ 5-6 weeks	110
☐ 2 weeks	1,299	☐ 7 or more	63

Some averages, percentages and totals have been calculated from the raw data of the tables. Much of this information is extremely interesting and in many cases quite valuable. These are here reported and numbered according to the tables above. It will be noted that this kind of information has not been calculated from all of the tables.

2. Average age of responding practitioners—42.6 years.

3. 96.5% of the respondents are male.

4. 95% of the respondents are Caucasian.

5.

California	— 7.5%	Ohio	— 20.9%
Chicago	— 9.3%	Temple	— 14.8%
Illinois	— 21.5%	Other	— 3.7%
New York	— 22.3%		

6. 76.5% of the respondents have D.S.C. degree; 19.8% have Pod.D. degree.

7. 3.44 years—average length of professional course of respondents.

8. 1.8 years—average pre-professional education of respondents. Of those who had pre-professional education, the average was 2.4 years.

9. 19.48% of the respondents have an academic degree of the baccalaureate level or higher B.A., B.S., M.A., M.S., Ph.D.). 1.88% of the respondents have a degree in pharmacy.

10. The respondents average 16.12 years in practice.

12. 49.0% of the respondents practice in cities of 100,000 in population.

14. 83.3% of the respondents are members of the national Association. The over-all response to the questionnaire was 40.19%. Membership response was 56.6%; non-member, 16.4%.

15. 50.5% of the respondents practice in a downtown business section.

16. 44.2% of the respondents practice in a professional building. 3.6% practice in a medical center.

17. 16.6% of the respondents have auxiliary offices and spend an average of 9.77 hours per week in those offices.

18. The average number of hours spent in the main or only office of the respondents is 37.54 per week.

19. The respondents average 1.03 days off per week.

20. 54.6% practitioners have evening hours and they average 2.24 evenings a week.

21. 37.6% of the respondents make house calls and they average 7.44 calls per month.

22. 35.4% of the respondents have no institutional connection; 19.8% serve on a hospital surgical service; 19.0% serve on other hospital service; 31.2% serve a nursing home; 28.8% serve a home for the aged. (It should be noted that the individual respondents probably served in more than one of these categories.) 3.7% perform a public or parochial school service and 5.9% are trainers or consultants for team events; 9.3% of the respondents serve some governmental institution; 1.1% are associated with the labor union health service.

23. 33.9% of the respondents make hospital and institutional calls and these individuals average 8.66 calls per month.

24. Apparently the tabulation of the respondents who stated they did not devote any days per month to institutional service, must have included some who spent only part of a day per month at an institution. Of those who spent one day or more in hospital or institutional service, the average was 3.58 days per month.

25. The average number of office treatments per week by the respondents was 63.27.

26. The average number of different people treated by our respondents was 730.03. This would indicate that more than 6 million different people see a podiatrist-chiropodist one or more times per year.

27. Our respondents estimate on the average that 17.38% of their practice is male.

28. Our respondents indicate that 10.03% of their practice is with children.

29. The average number of new patients admitted to the practice per month is 20.93.

30. The greatest source of referrals of new patients is from present patients—52.74%; 12.05% are from telephone directory; 7.87% are referred by doctors of medicine.

31. The average number of X-rays taken per month by respondents is 9.04.

32. The average number of pharmaceutical prescriptions written per week is 8.2.

33. Average number of prescriptions dispensed per week in the office is 4.3.

34. 35.5% of the respondents dispense, prescribe or recommend elastic hosiery. Their average is 2.56 pairs per week.

35. 24.4% of the respondents do not write shoe prescriptions. Of those who do, the average is 5.39 pairs per week.

36. The frequency with which respondents administer, prescribe or dispense per week, the following is:
    a. Local Anesthetics—14,811
    b. Antibiotics—11,338
    c. Corticosteroids—7,213
    d. Foot Powders—26,753
    e. Narcotics, Barbiturates or other Sedatives or Tranquilizers—6,262
    f. Vitamins or other Nutritional Supplements 9,185
    g. Peripheral Vascular Dilators—5,514
    h. Emollients, Lotions or Creams—29,449

37. 32.7% of the respondents dispense or fit custom-made, molded, contour or similar shoes, averaging 3.23 pair per month; 100 practitioners account for almost 1/3 of the total.

38. & 39. The average gross income for the year

1959 was $14,984.00 and the average operating cost for this year was $4,620.00 yielding an average net of $10,364.00.

40. Office rent accounts for 15.18% of overhead.

41. Office-used pharmaceuticals average $30.01 per month.

42. $37.15 is the average amount spent per month on surgical supplies.

43. $33.41 is the average amount spent per month for adhesive-backed materials.

44. The average income from surgery last year was $1,293.65 which is 8.6% of the average gross income.

45. The average income from appliances, devices, prosthetics in 1959 was $1,197.90.

46. & 47. The average estimated value of professional equipment is $4,200.77 and the average age of this equipment is 9.75 years.

48. & 49. The average value of non-technical furnishings is $706.44 with an average age of 7.29 years.

50. 12.1% of the respondents practice in association with another practitioner.

51. The average weekly earnings of an associate are $182.24.

52. & 53. 45.5% of the respondents have an office assistant whose weekly salary averages $29.25.

55. a. The average respondent has in his office 1.92 operating chairs.
    b. 80.3% of the respondents have one or more X-rays.
    c. 72.3% of the respondents have one or more whirlpools.
    d. 8.9% have one or more paraffin baths.
    e. 44.6% of the respondents have one or more ultrasonic apparatus.
    f. 42.5% have one or more diathermy machines.
    g. 39.7% have one or more ultra-violet machines.
    h. 68.1% have low voltage apparatus.
    i. 43.8% have an oscillator or percussor instrument.

56. 66.1% of the respondents participate in some form of community service.

57. The average number of postgraduate courses and conventions attended last year by respondents was 1.98. 653 attended none and of those that did attend, the average was 2.49.

58. The average vacation time, exclusive of attendance at conventions and postgraduate courses, was 1.95 weeks.

The reader must remember that the above statistics are only tabulations and some simple percentages and averages. Time did not allow for a complete detailed analysis of the many, many factors. Obviously, all these are closely interrelated and should be studied in relationship each with the other. It is in this type of cross-relationship that the true value of such a study is best shown.

In the months ahead, through the statistics gleaned from the questionnaires, many studies are planned, using this cross-relationship in its broadest sense. The information thus gained will not only be of the utmost value to the practitioner, but will give a detailed perspective of the profession at large.

The Council on Professional Information would like to thank all those who helped with this study. We are especially grateful for the cooperation of Secretary Abe Rubin and Executive Council Member, Joy E. Adams. It is the opinion of this Council member that the combined efforts of everyone concerned contributed much toward the advancement of the profession.

507 Liberty Ave., Pittsburgh, Pa.

"... President Theodore Roosevelt, who called the first Conference, said, 'Aggressive fighting for the right is the noblest sport this world affords' ..."

Marion D. Hanks,
General Authority,
The Church of Jesus Christ
of Latter-Day Saints

JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

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3301 Sixteenth Street, N.W., Washington 10, D. C.

A. RUBIN. D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S MESSAGE

Centralization of Activity

As the activities of the profession throughout its many facets have grown immeasurably in the past few months and because of closer liaison developed with outside organizations, such as allied health and medical groups, insurance groups, labor groups and Federal and state governmental groups, it becomes even more important that we stress the necessity of centralization of activity.

To this end I sincerely request all state officers, state secretaries and state chairmen of the various committees to make themselves well acquainted with the organizational structure of the councils and committees of the A.P.A. Before beginning any particular project that has not only state, but also national, significance, the particular division and councils thereunder, to which this activity may be particularly related, should be made aware of your intentions and plan of activity.

Likewise, it becomes the responsibility of the A.P.A. Divisions and their various Councils to make the states aware of their activity.

In an effort to better acquaint you with the organizational set-up of our committee structure, let me, if you please, reiterate it for you. The Councils and Committees of the Board of Trustees are divided into three groups.

1. The first is the Division of Internal Affairs, under the direction of the Second Vice President, Dr. Joy Adams.

2. Next is the Division of External Affairs, under the direction of the First Vice President, Dr. Benjamin Mullens.

3. Third is the Division of Special Affairs, under the direction of President Elect, Dr. Robert Shor.

I respectfully refer you to the Directory of Councils and Committees, located in another part of the Journal, for the make-up and names of the men who are on these particular councils.

The common duties of these divisions are to investigate, evaluate and prepare special reports and make recommendations regarding their special area of activity upon request of the Board, and to initiate special projects for approval, submitting a plan and the budget requirements.

Under the Division of Internal Affairs is the Council on Scientific Sections which concerns itself with the various technical, specialty and subspecialty aspects of the professional service and maintains liaison with the specialty groups. Also, in here is the Council on Professional Information whose area of activity is in regard to regional, state and local publications, state legislation and practice privileges, history, library, museum, professional economics and office assistants.

Thirdly, the responsibility of the Council on Membership Development lies with the recruitment and retention of members, liaison with students' organizations and component state societies, ethics and the Association insurance service, namely, the NAC Agency.

Under the Division of External Affairs is listed the Council on Public Education and Information. This area of activity relates to informational materials such as pamphlets, leaflets, audio-visual aids, public communications media, vocational guidance and liaison with the American Foot Health Foundation.

The Council on Allied Health Relations' area of activity is concerned with relations with medicine, dentistry, nursing, hospitals and other related sciences and prepaid health plans.

The Council on Extra Professional Relations is concerned with our relations with industry, commerce, labor, service and professional groups.

The Division of Special Affairs concerns itself with special projects, some of which may have some extramural contact and activity. This division includes the Audio-Visual Council, the Council on Podiatry Therapeutics and Pharmacy, the Council on Foot Gear, and likewise it is concerned with special committees as listed on the directory page of this Journal, namely, Child Foot Health and Youth Fitness, Aging, Farm Foot Health, Nomenclature, Civil Defense and Medical Liaison.

A special committee of the Board of Trustees has been established to pursue the national program and to guide and assist state programs seeking proper coverage in health insurance policies and contracts for our patients.

By each of the state societies and all of the various affiliated specialty organizations and other affiliated groups making themselves fully aware of the activities of these various councils and committees and the men who are responsible for them, it will be much easier to develop a true centralization of activity. This, therefore, becomes a better means of reducing duplication of effort and also assists those who are starting some project by being in touch with those who have had experience with the particular subject.

It is my earnest desire to make all of you fully acquainted with all ramifications of activities within the A.P.A., which is your organization and is a service organization, to assist you in whatever facet necessary to help promote the profession and to provide better foot health for the people we serve.

MARVIN D. MARR, D.S.C.

NEWS OF THE PROFESSION IN GREAT BRITAIN

FRANKLIN CHARLESWORTH, Ed.D., D.S.C., F.Ch.S.
Manchester, England

A regular series of "letters" about the profession in Great Britain, by Mr. Charlesworth, Editor of the British Chiropody Journal, or arranged for by him, will appear in this column.

Private practice in Britain has had rather a lean time this summer on account of the consistently bad weather. People have just not been getting about as they would have had the weather been more seasonable. As a result they have not found it necessary to visit their chiropodist so frequently.

As you no doubt already know, a large proportion of practitioners in this country confine the scope of their work within a very narrow definition which means that it is primarily palliative in nature. Such practitioners suffer more acutely during a summer of bad weather than those with a broader approach to practice.

I have frequently endeavoured to emphasise the fact that the practitioner who approaches treatment with an appreciation of the full significance of the words aetiology and prognosis, with a knowledge and skill that will enable him to aim at a positive end result will develop a practice less affected by the vagaries of our climate than those who only provide a palliative service.

There is, however, a distinct movement towards a broadening in the scope of practice but it is slow and timid in official quarters. Several modalities that are essential to the adequate treatment of many conditions are still frowned upon, but those who have been bold enough to broaden their scope of practice and have experienced the gratification and possibilities of a more positive and effective approach are inducing the desired change of outlook, which, if somewhat slow and belated, is now positive.

It has been very delightful receiving and entertaining a number of our American colleagues in this country who, in the course of an European tour, have contrived to spend a day or two in Britain. Whilst these visits have nothing like the significance of the official visit of Dr. Shapiro, the President of the American Podiatry Association, they are nevertheless fostering a spirit of friendship and good will which is most desirable. We are doing our best to make their brief sojourn amongst us pleasant, which is as little as we can do in return for the great volume of hospitality and good fellowship which you in America have shown whenever the opportunity has presented itself.

We are looking forward to receiving Dr. H. L. Collins of Columbus, Ohio, who is attending our convention at Norwich where he is to lecture following a visit to our London clinics. He is paying a visit to Ireland and then coming to Manchester where he is to stay with me for a few days, in the course of which he is addressing a meeting of the Manchester and District Branch of the Society of Chiropodists and members of adjacent branches who have been invited to attend. This meeting is taking place at Hope Hospital where my own Department of Foot Orthopaedics and Prosthetics is established.

Later in the week Dr. Collins and I are visiting Edinburgh to address a one-day conference of the Edinburgh branch of the Society. Whilst in Scotland Dr. Collins will spend a few days visiting famous beauty spots in this delightful country.

So it goes on. These visitations backwards and forwards across the Atlantic,

bringing forth consultations and interchange of ideas, leading ultimately to mutual cooperation.

All this is very gratifying and is leading up to the international convention in Washington, D. C., 1962, and I hope an official contingent will be representing Great Britain.

To those of us who are working towards international good fellowship and understanding and ultimate cooperation in our mutual interest, the achievement of an international conclave of this nature will be most gratifying. I am sure that Dr. Marvin Shapiro is looking forward to it with great hope and expectation as the culmination of the task which he undertook and successfully concluded in his recent visit to Europe and Russia.

I feel that my American colleagues have worked so hard for the establishment of these good relations that they deserve nothing less than complete success for this international event.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Ger-O-Foam

Composition: Methyl salicylate, benzocaine, volatile oils in a specially processed, neutralized emulsion base, for aerosol use.

Action and Uses: The analgesic and local anesthetic agents are deeply absorbed percutaneously with the fatty base to permeate to affected sensory endings. Affords relief within minutes lasting for hours in such musculoskeletal disorders as: rheumatoid arthritis, osteoarthritis, painful limbs following C.V.A., rotator-cuff tendinitis, painful healed fracture, fibromyositis, torn muscle, phantom limb pain, muscle sprains and low back pain. Enhances the usefulness of massage by reduction of pain and spasm and so permits exercise not possible before, with improvement in function and range of motion.

Application: Gently massage Ger-O-Foam into distressed area. May be used after diathermy.

Supply: Ger-O-Foam, in aerosol can. By Geriatric Pharmaceutical Corp., Bellerose, L. I., N. Y.

Vi-Dom-C Oral-Tabs

Composition: Each Vi-Dom-C Oral-Tab contains Vitamin C (Ascorbic Acid from Sodium Ascorbate) 1335 mg. in a specially formulated buccal tablet for the oral administration of large doses of Vitamin C by absorption through the buccal mucosa. They are pleasantly flavored and dissolve slowly.

Indications: Subclinical adult scurvy; Miliaria; Purpura; swollen and bleeding gums; slow healing of wounds; Gingivitis; iron deficiency anemia; weakness, irritability, vague pains and weight loss resulting from Vitamin C deficiency; synergy with Vitamin A in the treatment of Acne and the common cold; to correct capillary fragility and abnormal capillary

permeability by its effect on the cement substance in the capillary walls; poison oak; Burns.

Advantages: Vi-Dom-C Oral-Tabs maintain the stability of Vitamin C in dry form, whereas the aqueous solutions become oxidized and lose their antiscorbutic activity. High blood levels of Vitamin C are rapidly obtained by absorption through the oral mucosa, thus increasing its effectiveness in collagen formation and connective tissue metabolism.

Method of Use: One Oral-Tab daily placed in the mouth and allowed to dissolve slowly for absorption through the buccal mucosa. Increase to two Oral-Tabs daily if symptoms of deficiency are severe. Patients may chew and swallow Oral-Tabs if necessary.

Supply: Bottles of 25 and 100. By Dome Chemicals Inc., 125 West End Ave., New York, N. Y.

Caldecort Ointment

Description: Dermatologic ointment. Each gram of Caldecort Ointment contains calcium undecylenate 30 mg. (3%); hydrocortisone acetate, 10 mg. (1%); neomycin sulfate, 5 mg. (0.5%) (equivalent to 3.5 mg. neomycin base) in a water-washable base. Caldecort is a stable, nonirritating, virtually nonsensitizing preparation.

Indications: Effective therapy for a broad range of allergic, inflammatory and infected skin disorders including atopic dermatitis, contact dermatitis, mycotic dermatoses, impetigo, otitis externa, infected eczematoid dermatitis, pruritis ani and anogenital pruritus.

Advantages: Caldecort combines antifungal, antibacterial, antiinflammatory and antipruritic action to relieve itching and inflammation promptly and to control bacterial and fungal infection. It is effective where antibiotic preparations alone often fail because of its active antifungal ingredient, calcium undecylenate.

Administration and Dosage: Apply to affected areas 2 or 3 times daily.

Supply: 7 gm. (¼ av. oz.) collapsible tubes. By Maltbie Laboratories, Division of Wallace & Tiernan, Inc., Belleville 9, N. J.

Bur-Veen
Wet Dressing Powder

Description: This is a new concept in wet dressings, which provides the therapeutic effect of Burow's solution plus the colloidal protection of Aveeno. Aveeno is a specially prepared colloidal oatmeal widely used in dermatologic bath therapy. The Aveeno provides a soothing colloidal medium for the modified Burow's solution.

Indications: Wherever Burow's solution is indicated, for weeping, inflamed, acute skin conditions.

Active Ingredients: Aveeno Colloidal Oatmeal, aluminum sulfate, calcium acetate (combines in solution to make fresh modified Burow's solution with Aveeno).

Administration: Pour contents of one Bur-Veen packet into a pint of cool or lukewarm water and stir well. The solution should be stirred before each use. It should be kept in refrigerator when not in use and discarded after 2 or 3 days. For wet dressings or compresses, soak bandage (soft linen or torn sheet, etc.) in the solution and apply loosely to affected area. Remove bandage every 20 or 30 minutes, soak in the solution and re-apply. Continue this procedure for 4 to 8 hours—or it may be varied as desired. For soaks, prepare the solution in basin. Immerse affected area in the solution for 20 to 30 minutes, allowing about 30 minutes between soaks. Continue this procedure for 4 to 8 hours—or it may be varied as desired or indicated.

Supply: Bur-Veen Wet Dressing powder is available in boxes of 6 and 100 packets. Each packet, when added to water, makes 1 pint of 1:20 Burow's solution equivalent, with Aveeno. By Aveeno Corporation, 250 West 57th Street, New York 19, N. Y.

Furaspor Cream

Description: For fungal infections. Formula: 1% Furaspor (brand of nitrofurfuryl methyl ether) in an odorless, nonstaining, vanishing-cream base. Furaspor is one of the antimicrobial nitrofurans.

Indications: Dermatomycoses as tinea pedis, corporis, cruris, barbae, capitis, anovulvar pruritus caused by Candida (Monilia) albicans. Furaspor has a wide antimycotic spectrum. It kills spores, helping to prevent constant reinfection. It is bactericidal to both gram-positive and gram-negative organisms, thus controlling the usual secondary bacterial infections.

Directions: Wash the infected area and dry well. Rub in Furaspor Cream until it disappears. Repeat morning and night. Reapply after washing, as of the hands. If acute inflammation exists, this should be first reduced with KMnO4 or aluminum subacetate soaks, before applying Furaspor Cream.

In tinea capitis apply morning and night to the shaved scalp. Shampoo weekly. Wear skull cap constantly, boiling it daily. Epilate fluorescent hairs every two weeks.

An occasional case of sensitization may occur. Instruct the patient to terminate treatment, wash the area and report to you if local erythema, rash or pruritus appears.

Supply: Packaged in 28 Gm. jars. *Keep tightly closed.* By Eaton Laboratories, Norwich, N. Y.

BOOK REVIEWS

TUMORS AND TUMOROUS CONDITIONS OF THE BONES AND JOINTS

Henry L. Jaffe, M.D., Director of Laboratories and Pathologist, Hospital for Joint Diseases, New York, N. Y.; Consultant, Armed Forces Institute of Pathology, Washington, D. C. 629 pages, with 701 illustrations on 194 figures. Index, Philadelphia, Lea and Febiger, 1958.

This book is a complete account of tumors and tumorous conditions affecting the bones and joints. Dr. Jaffe uses a multiform approach to the subject, intertwining the clinical aspects with the roentgenographic and pathologic findings. Each chapter presents a clear, concise, but comprehensive exposition of each of the main types of lesion. This publication is destined to become a recognized text.

The close interrelationship between roentgenology and other specialties is best shown by the investigations of Dr. Henry L. Jaffe, a pathologist at the Hospital for Joint Diseases in New York. We are greatly indebted to him for his contributions and cognition of such entities as: chondromyxoid fibroma, chondroblastoma, osteoid osteoma, aneurysmal bone cyst, desmoplastic fibroma, and related works in this field.

In the preface, the author acknowledges that this book conveys many of his personal conceptions of the lesions discussed. Recognizing the importance of the work of others in the field, he cites these authors and their contributions. However, from the literature and reports of collected cases from various clinics, it is evident that the author's concepts, though slow in gaining acceptance, are now widely recognized and approved.

In his introduction, the author contends that the diagnostic approach in interpreting a bone lesion is best attained by a "tridimensional" view. To achieve a synthesis of analysis, the individual radiologist, surgeon, and pathologist should not only be able to view the diagnostic problem from his specialized point of view, but also from that of each of the other two.

As distinguished from the conventional classifications, Dr. Jaffe offers us an interestingly new and enlightened conception of

bone tumors. He feels that to group various types of bone tumors according to their cell type or tissue of origin, is not as practical as to approach the lesion from its entire biologic conduct — its histological, radiographic, and clinical aspects. With this concept, the author is able to introduce some important diagnostic views. For example, he feels that in addition to making a diagnosis of typical giant cell tumor, "one should attempt to grade the lesion according to the cytologic variations relating to the stromal cells." He subclassifies the tumor into three grades: "I, II, and III—showing, respectively, no appreciable, moderate and pronounced atypism of the stromal cells, the giant cell tumors of grade III presenting a sarcomatous stroma and being frankly malignant." This histologic pattern enables the clinician to better evaluate the pathological and clinical characteristics in relation to treatment and prognosis.

Each subject has an introductory paragraph which includes definition, general considerations and nomenclature. In the section "Clinical Considerations," there are the following sub-headings: Incidence—including sex and age, Localization, Clinical Complaints and Findings, and Roentgenographic Findings; under the heading of Pathology and Pathogenesis, there are Microscopic Pathology, Gross Pathology, Nature and Genesis. Terminating each chapter, is Differential Diagnosis and Treatment. In regard to treatment, the author contends that "attention is devoted mainly to the choice of procedure appropriate for each condition."

The subject matter is well illustrated with excellent reproductions of roentgenograms, accompanied by photomicrographs of the histologic patterns and photographs showing gross pathology of whole and resected bones and tissues. "The illustrations are arranged in full page plates to permit the simultaneous display of a number of pictures for purposes of comparison." The accompanying titles and descriptions give sufficient information about each illustration to perform the function of a case history.

A reference containing an adequate index of subject and author is provided at the end of each chapter.

Podiatrists will find this work interesting since 21 chapters contain references to the foot as the site of many tumors and tumorous conditions. There are 165 roentgenographs of the lower extremities, and 8 which directly concern the foot. In addition, there are 79 photographs of gross sections, some enlarged, of the affected lower limbs.

This well-bound volume appears on high quality stock with large, readable type.

"Tumors and Tumorous Conditions of The Bones and Joints" should find a useful place on the reference shelves of any medical or podiatric library. Podiatrists should not fail to add it to their library.

M. M. Ringel, Pod.D.

ARTHRITIS: MEDICAL TREATMENT AND HOME CARE

Dr. John H. Bland, Director of the Clinics for Rhematic Diseases at Mary Fletcher Hospital and DeGoesbriant Memorial Hospital in Burlington, Vermont, $4.95, 208 pgs., illustrations, photographs, Glossary, Appendix and Index. Published by The Macmillan Company, 60 Fifth Avenue, New York 11, N. Y., January 5, 1960.

Dr. Bland begins with an unusually thorough discussion of the aspects of patient care and treatment in Osteo and Rheumatoid Arthritis. He describes in nine well-detailed chapters, Goals and How to Achieve Them; What are Arthritis and Rheumatism?; The Antiquity of Rheumatism; Treatments Tried and Discarded; Two Major Rheumatic Problems, Home Management of Rheumatoid Arthritis; Home Care of Degenerative Joint Dis-

ease (Osteo Arthritis); Specific Instructions for Home Applications of Physical Therapy and War Against Rheumatism. The author also provides a most comprehensive Glossary, Appendix, Index and information for the arthritic with organizations devoted to education, research and treatment as well as clinics that specialize in the treatment of arthritis. Basic investigation of joint diseases, and the study of pathogenesis and clinical manifestations, have been expanding rapidly during the past decade. In this practical volume, Dr. Bland has contributed valuable material on the constructive treatment and management of the arthritic patient, particularly those suffering from Rheumatoid Arthritis. He discusses what you, the practitioner, can recommend to your patient in the way of drugs, physical therapy, psychotherapy, orthopedic management and care of the patient in bed. Dr. Bland emphasizes the pathophysiology of rheumatoid arthritis and its current therapy, for this is now the outstanding incapacitating joint disease.

You will find a concise and thorough description of current up-to-date treatment methods for osteo and rheumatoid arthritis which crackles with practical facts and brisk instructions. They're written for quick reading and fast comprehension. This fine text is a complete reference on the treatment of the osteo and rheumatoid diseases. The criterion of this book is its effectiveness and newness and the ability of this volume to remove your doubts about whether or not there is some better treatment you have perhaps overlooked. You will also find additional features that add much to the value of this text, such as a three-page listing and photographs of "Hope for the already Disabled," Self-Help Devices; two pages of Major Organizations Devoted to Education, Research and Treatment; 13 pages of Clinics that Specialize in the treatment of Arthritis in the United States.

In his preface, Dr. Bland states that, "Rheumatoid Arthritis and Osteoarthritis are the two chronic diseases for which more can be done than any other comparable disorders in the chronic disease category." He also lists two most important and required demands in the treatment of arthritis: 1. Education about the nature and characteristics of the disease; 2. The learning of concepts and techniques of treatment. Other interesting facts brought out by Dr. Bland are that three times as many women as men suffer from rheumatoid arthritis and that 80% of the cases occur between the ages of 20 and 50 with peak incidence at 35 to 40 years.

The author has produced an interesting book which presents the general nature of this complex problem. Newly developed techniques of rehabilitation involving the use of self-help devices and of training disabled homemakers are adequately presented. Shoes, shoe corrections, postural training, the function of nurses, physical therapists in treatment of rheumatic diseases, the philosophy of using heat such as infra-red, hot packs, heated paraffin, warm tub baths, exercise, traction apparatus, splinting, appliances, diathermy, whirlpool and ultrasonic therapy and the role of the voluntary health agencies in supporting and improving the lot of the arthritic patient are discussed. This book is worth studying and owning. It speaks for the author's rounded-out experience with arthritic problems.

Jack Ranzer, Pod.D.

Procrastination is the art of keeping up with yesterday.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

DIAGNOSIS

Judicious Use of Laboratory Data in the Management of Major Physiologic Problems in Surgery, Randall, H. T., Anesth. & Analg. 38: 503-12, Nov.-Dec. 1960.

Since a large number of laboratory determinations can be made, 25 or more in a small laboratory, to several hundred in a large medical center conducting extensive research, the surgeon must know which ones are specifically needed in treatment of a case, and must be aware of the inherent errors to be expected in each test. Since laboratory studies are costly, it is important that the minimal number be ordered that will be compatible with good care.

Most laboratory determinations are not diagnostic in themselves but are guides to the clinician in evaluating the status of the patient. Many experienced surgeons will predict with considerable accuracy what a laboratory test will show, from his understanding of the clinical condition. Laboratory tests, however numerous, cannot substitute for a carefully taken history, thorough physical examination and clinical judgment. "If the laboratory report does not fit the clinical picture, the patient should be re-examined and the laboratory determinations repeated."

Not only is there a long range of "normal values" in man for the most used tests, but there is a range of wide magnitude in the inherent error in the process of making the test. For example, in a meticulous platelet count there is a known error of 11 per cent, but by the usual method of counting 95 per cent of the counts fall within plus or minus 50 per cent of the true value.

Certain baseline determinations are supposed to be made before elective surgery, including blood count (hemoglobin, hematocrit, white blood count and differential) and an urinalysis (specific gravity, glucose, acetone, albumin, and microscopic inspection of urinary sediment). A chest x-ray taken not more than 6 months earlier is a wide precaution, and especially in patients less than 45 years of age; in emergency cases only the chest x-ray can be omitted. Other required tests are blood urea nitrogen or nonprotein nitrogen determinations in patients with albuminuria, hypertension, or enlarged prostate; blood sugar test if the urine shows glucose or in the presence of diabetes; in cases of asthma, emphysema, or other chronic obstruction of the respiratory tract, CO_2 content and serum chloride and if possible whole blood pH.

DRUG THERAPY

Treacherous Tranquilizers, Shaw, C. C. and Felts, P. W. Anesth. & Analg. 38: 319-27, July-Aug., 1959.

The amazing advances in science and technology have brought an Age of Anxiety. Man is anxious about himself, about continuance of our democracy, the American way of life, and about fundamental religious tenets. Continually trying to escape national and international frustration, he resorts to tranquilizers to secure peace of mind. Peace of mind is transitory.

The tranquilizing drugs, however, work not only on the mind, but affect the gastrointestinal tract, cardiorespiratory system and the endocrine glands. Treatment with these agents is symptomatic only. Under controlled hospital and institutional conditions they bring the psychotic patient back to reality and are valuable. Their indiscriminate use is condemned.

The real purpose of treatment with tranquilizers is reduction of pathologic anxiety to one of normal degree and to keep it within reasonable bounds so that the individual can live with his anxiety. Anxiety and tension should not be abolished, but used constructively, for they can lead to ambition and accomplishment. Yet, although 30 per cent of patients will react favorably to placebos, in 1958 physicians wrote 50 million prescriptions for these "Peace Pills."

The tranquilizers are classified in four groups, according to their chemical composition: (1) Rauwolfia alkaloids; (2) phenothiazine derivatives; (3) benzhydrol compounds; (4) propanol derivatives which include mephenesin and meprobamate. In all, there are about 100 brands of tranquilizers, each with a different trade name.

The criteria in choice of a tranquilizer to induce emotional calm are: (1) One that will produce a rapid therapeutic response; (2) that will be effective in a majority of cases; (3) that will not lead to addiction; (4) that toxicity will be minimal; (5) secondary side effects are few; (6) continued use not followed by tolerance; (7) is suitable for inpatient and outpatient use; (8) does not dull the senses, decrease perception, nor interfere with mental acuity. Since all patients do not respond in the same way, the physician should know the psychopharmacology of each drug and the psychodynamics of each patient.

The indication for administering a tranquilizing drug is, chiefly, relief of anxiety, manifested by psychomotor tension (headache, backache, restlessness, irritability, overfatigue, undue nervousness, difficulty in concentration, insomnia).

The tranquilizers may be helpful also in phychosomatic disorders (allergy, dermatitis, gastrointestinal distress, and some cases of cardiovascular disease). In neuromuscular tension states meprobamate is helpful because of its muscle relaxation properties.

Whichever tranquilizing agent is used, close clinical supervision is necessary, as some have treacherous side effects. All are potentially toxic and therefore self medication is very dangerous. The side effects are both organic and psychologic. A lowered resistance to disease is the most insidious side effect and demands large doses of antibiotics. Chronic cardiac patients receiving ataractic drugs may develop cardiac decomposition. Coma may be precipitated in diabetics. Bedfast patients may develop serious topical ulcers of the heel which become recalcitrant to treatment.

Long continued treatment with tranquilizers can lead to lethargy, then extreme restlessness, followed by agitation and mental aberration.

MUSCULOSKELETAL DISORDERS

The Adolescent and Athletics: Orthopedic Aspects, Sigmond, H. Pediatric Clinics, North America 7: 165-71, 1960.

Children do not complain of injuries for more than one day unless something is wrong. They do not limp for more than one day unless there is a real lesion. A normal child may have been a victim of some violence or trauma, or a congenital anomaly may become manifest at this time, or there may be an epiphyseal condition peculiar to adolescence.

A "sprained *wrist*" is rare, but fracture of the carpal scaphoid is common. Stress or fatigue fracture can result from a merciless pounding of the knees in strenuous athletics, but occurs more frequently in the ankles. High school coaches and trainers favor ankle wrapping; this should be encouraged in adolescents. *Ankle* sprain is uncommon in adolescents, and will be neglected when it does occur. The ligamentous support of the foot and ankle may be completely torn asunder. The only sensible

dressing is a rigid plaster boot, worn until the ligaments heal. *Knee* injuries are more serious than those of the ankle. Diagnosis is easy because of the swelling and soreness. Prompt repair is necessary if a collateral ligament is torn; if delayed the individual will be out of athletics for life. (Methods of treatment are described for dislocated patella, locked knee, and deranged knee.)

Muscle contusion when violent can lead to myositis ossificans.

Anomalies.—Congenital skeletal anomalies are usually in the spine and foot. Backache during adolescence is usually caused by such disorders. *Idiopathic scoliosis,* seen in adolescent girls, does not require limitation of athletic pursuits — unless orthopedic therapy is being administered.

Congenital anomalies of the foot manifested during adolescence may be an accessory scaphoid, seen as a large bony knot at the inner side of the foot over the scaphoid bone. If large enough it can cause inflammation of the skin and subcutaneous tissue, because of shoe friction during play. Its excision is advised. *Spastic flat foot,* an anomalous articulation under the talus, causes limping because of pain and an inability to run. Examination shows the foot in rigid fixation, spasticity, and inability to move the forefoot on the hindfoot. Radiologic examination shows a talocalcaneal or calcaneonavicular bar and a characteristic beak on the articular margin of the head of the talus. Following arthrodesis, normal activities can be resumed.

Commonly occurring are adolescent round back, epiphysitis of the spine, adolescent kyphosis, and Scheurmann's disease. These are aggravated in adolescent boys doing heavy work or excessive lifting, or by weight on the spine. Fathers tend to over-urge their sons to athletic pursuits. In the cases mentioned, football, weight lifting, and hammer throwing are forbidden; limited amounts of basketball, baseball, and tennis are allowed. A stone bruise of the adolescent can cause epiphysitis of the apophysis of the heel bone. The enormous pull of the tendon of Achilles which occurs with each step on take-off accentuates the injury. A lift in the shoe diminishes the amount of take-off with each step. Running and jumping prolong this complaint.

Slipped femoral epiphysis is often overlooked. The adolescent walks with a hip limp and complains of pain in the knee or around the hip, or a "catch" in the hip. This should be recognized before a deformity occurs. It can be detected early by observation of the manner in which flexion at the hip joint occurs during examination. The patient cannot flex the hip with the knee flexed to bring the knee toward the opposite shoulder.

Deformity develops slowly; if treated the hip can be spared much damage. Putting the child to bed with a little traction often is enough. All kinds of play should be forbidden until epiphysis of the hip joint is healed. Protection should be provided against all activity involving the legs with superimposed rest.

The Waning Joint, Jeffrey, M. R. Amer. J. M. Sc. 239:104-24, 1960.

A detailed discussion is presented answering the question, where does normal aging of the joint end and osteoarthritis begin. Deterioration of the knee joint begins early; 9 per cent are initiated during the third decade and up to 48 per cent in the fourth, and 100 per cent of all knees have established changes by the age of 80. Changes in the knee are followed by alterations in the great toe, hip, and elbow, with little difference in incidence in these three joints. A radiologic study of a sampling of people aged 55 to 64, showed such changes in 87 per cent of women and 83 per cent in men. Of the various joints examined, the distal interphalangeal joint was most often affected, and the metatarsophalangeal and knee joints next.

Although the tendency to develop a degenerated joint may be inherited, in general such a joint indicates its inadequacy to endure the stresses which come with normal functioning. Osteoarthritis is apt to develop when abnormal stresses act on a normal joint, or normal stresses act on an abnormal joint. Among the numerous predisposing factors are those which injure the cartilage primarily, and those imposing abnormal mechanical conditions by increasing stresses on the joint. The first includes direct trauma, epiphyseal abnormalities, inflammatory arthritis, and metabolic disorders such as gout or ochronosis; the second includes deformities from bone disease, malalignment because of postural defects, and abnormal stress from obesity or from excessive use. A high incidence of osteoarthritis is noted in the knees of women because of over-weight. Heberden's nodes, idiopathic or traumatic, occur oftenest in women and seem to be an inherited characteristic. Obese men have a high incidence of Heberden's nodes in addition to osteoarthritis in weight-bearing joints.

The role played by occupation depends upon the degree of trauma. Prolonged strenuous use of repeated trivial injuries can be equally damaging. Endocrine factors play a small role. Endocrine abnormality at menopause is not a factor as the disease commonly appears first 20 to 30 years before menopause.

The articular cartilage is particularly affected. So long as normal hyaline cartilage is bathed by synovial fluid, it is alive and healthy. But the milky white articular cartilage of youth soon loses its early smoothness; senile changes begin in the second and third decade in the knee—it has been said that an entirely normal, smooth weight-bearing cartilage is rare at the age of 30. The earliest changes in articular cartilage begin in sites of the greatest stress or pressure. The cartilage becomes frayed or blistered, superficial flakes are lost, and cracks appear. The immediate subchondral bone thickens and is remodeled; at the circumference of the cartilage proliferation of bone and cartilage may be noted. Finally, with the wearing away of weightbearing cartilage, dense eburnated subchondral bone is exposed and trabeculae are thickened and atrophied, or are collapsed. The eburnated surfaces develop furrows because the dense bone ends cannot withstand the trauma of use; they become remodeled and distorted. As cartilage substance is flaked off, fissures spread deeply into the substance of the cartilage, producing perpendicular cracks. With wearing away of the superficial layer, the cells beneath die and the matrix is lost as the cartilage wears away. Cartilage loses its resilience and softens with progressive loss of matrix and advancing years. Hyaline cartilage has no capacity to replace itself after disease or injury.

Prevention of osteoarthritis is impossible until a way is found to arrest the degenerative process in articular cartilage and to diagnose its earliest changes. Predisposing factors such as obesity and poor posture may be eradicated and meticulous care taken of injuries, deformities, and diseases of bones and joints in the young. Management is avoidance of predisposing or aggravating factors, and proper use of rest and therapy. Avoidance of excessive use of an affected joint is imperative.

Salicylates remain the most effective drugs. The uselessness of exotic remedies will be appreciated if one remembers the inability of adult cartilage to regenerate. Phenylbutazone may be effective when other measures fail to relieve severe pain. Systemic use of steroids is not justified. Hydrocortisone may help if pain is caused by inflammation secondary to trauma. Radiotherapy may give symptomatic relief in older patients with severe refractory symptoms, but only temporarily.

NERVOUS SYSTEM

Peripheral Entrapment Neuropathies of the Lower Extremity, Kopell, H. P., and Thompson, W. A. L. New England J. Med. 262: 56-60, 1960.

A peripheral entrapment point may occur in the course of a nerve, if the anatomic configuration produces constriction of the nerve, or if that area has been traumatized, the particular anatomic disposition will maintain the nerve in a state of inflammation. Pressure is exerted on both the nerve itself and on its intrinsic blood supply. A significant characteristic is rest pain, which becomes more severe at night. There is tenderness at the entrapment point, and the nerve trunk often is tender proximal and distal to this area.

Symptoms are relieved by injection of an anti-inflammatory agent into the area. If inadequate or transient relief is obtained, the mechanical basis of the inflammation is still active and surgery is indicated. If untreated, many of the cases become asymptomatic in 6 to 9 months. Others remain symptomatic for many years, and may lead to secondary hyperfunction of the autonomic nervous system—adding to the diagnostic problem. The following characteristics are known:

1. Entrapment of the sciatic nerve may occur where it emerges into the retropelvic area. A diagnostic sign is pain accentuated on internal rotation of the hip and relieved by external rotation, if the sciatic nerve is stretched by straight leg raising, not quite to the discomfort point.

2. Another area affected is where the obturator nerve leaves the pelvis through the obturator canal to reach the thigh. Entrapment at this point is a major source of pain in osteitis pubis. The pain may extend from the groin to the knees.

3. Entrapment can occur where the lateral femoral cutaneous nerve pierces the attachment of the inguinal ligament just below the anterosuperior spine. This causes a burning pain and hyperesthesia of the anterolateral aspect of the thigh. Postural alternation, to relax the tensor fascia by use of shoe lifts and stretching exercises, is of little, if any, effect.

4. Entrapment of the peroneal nerve in its course around the fibular neck can be produced by inversion plantar-flexion of the ankle and foot. If the neuropathy continues for some time, the pain becomes localized to the lateral area of the leg and lateral dorsal region of the foot. Inversion of the foot produces pain. A mistaken diagnosis may be made of chronic subluxation of the talus in the ankle mortise under inversion stress.

5. The posterior tibial nerve may be subjected to entrapment neuropathy in the ankle or in the foot after leaving the posterior aspect of the leg. The nerve divides at the digital edge of the retinaculum into calcaneal, medial, and lateral plantar branches. The branches of the calcaneus supply sensation to most of the heel, the plantar to the small muscles of the sole of the foot, the associated joint structures and cutaneous sensation of the sole and toes. Although the calcaneal branches are well cushioned by the overlying trabeculated fat pads, they are liable to direct trauma, producing persistent pain as in a heel bruise. Exploration of these nerves has upset many old traditional orthopedic beliefs regarding foot strain and its causes. The basic sources of pain in many cases are localized neuropathies, not inflammatory responses in the ligaments, joints or muscles. These neuropathies can cause a prolonged disability.

6. Digital nerves deriving from the medial and lateral plantar nerves may be traumatized by the transverse intertarsal ligament. Neuroma originating at this forward edge of the ligament is not due to compression of the nerve between the metatarsal heads, but to the ligament which prevents interposition of the nerve between the bone ends. The most frequent site of

neuroma is that formed by anastomosis of the medial and lateral and plantar nerves. If at the base of the web between the third and fourth toes, it is called Morton's neuroma. This nerve irritation and inflammation occur at other interspaces also.

Diagnosis can be confused by the presence of other disabilities: symptomatic low-back derangement, diffuse nerve-trunk tenderness, atypical pain distributions, secondary autonomic nervous system hyperfunction, and by the presence of injuries of the ankle or foot causing pain and disability. The concurrent neuropathy can be overlooked and the complaint attributed to ligamentous joint residuals.

Diagnosis may be aided by use of local infiltration of the area with hydrocortisone. If this brings symptomatic relief of pain, it indicates that the nerve trunk is inflamed in some area. But if relief is repeatedly transient, it is evident that the mechanical basis of the irritation is still active, and neurolysis is indicated.

NEW GROWTHS

Local Injection of Vitamin A (Keramin) for Plantar Verruca, Gilbert, R. S., and Williams, M. J. U. S. Armed Forces M. J. 10: 843-47, 1959.

A report is given of an 18-month study of 100 patients with plantar verruca treated with massive doses of vitamin A (Keramin) injected into the lesion. Keramin has a vitamin A activity of 50,000 units per ml. Following anesthetization with Xylocaine hydrochloride, with a 26-gage ½ inch needle in a tuberculin syringe, Keramin was injected deep into the verruca, with care to avoid a vein. The initial dose should not exceed 0.1 ml. per sq. cm. of the verrucose area. Injections were given at weekly intervals, gradually increasing the dose up to 0.3 ml. The mosaic warts were injected from two to three different angles, using in some cases 0.4 to 0.5 ml. Complete resolution occurred in 82 per cent; relief of pain in 95 per cent. The average number of injections was 4.2. One patient with resistant mosaic verruca required 14 injections. Five patients needed only one. If resolution did not appear after three to four injections, the treatment was discontinued. The only reaction was a mild itching around the site of injection in a few patients, and lasting from 2 to 12 hours. The patients were able to return to work immediately. The only dressing used was an adhesive strip; this did not interfere with bathing. No recurrence was reported in 6 months; 14 patients have had no recurrence in 15 months.

MISCELLANEOUS

Metric Versus English Units, Wolffe, Dael, Science 131: January 22, 1960.

The advantages and disadvantages of adoption of the metric system are repeatedly being presented, without bringing a decision for either side. It is thought by advocates on both sides that Congress this year may call for a thorough study of the problem. The metric system will be easy to learn and use, and some aspects of conversion will be easy, for example, in the food, chemical and pharmaceutical industries. However, in changing heavy equipment and machines, and their many parts, the process will be difficult and costly. Whether compulsory adoption is advisable, as advocated by the American Geophysical Union, and opposed by the AAAS Committee on Metric Usage, remains undecided. Whether the change, if made mandatory, should be subsidized by the nation in protection of those industries which will incur the heaviest expense in converting to the metric system, is an added problem. The question is asked, are the advantages of this system, in this age of widespread interest in science, as important as they once seemed to be?

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

CALIFORNIA

California Podiatry College and Hospital

First patients admitted May 15, 1960. Through July 31, 1960, a total of 178 patients had been hospitalized. Of these, 146 were patients of podiatrists in private practice, 32 were referred by the clinic. Of the 178 patients, 155 had insurance, 23 had not. All insurance claims have been honored. Gross patient charges to July 31, 1960, were $31,218.

A formal statement of patient-intake policy has been declared by the board of trustees and widely distributed to community agencies, A.P.A. members and nonmembers. It appears in poster form in the clinic waiting room and reads, "It shall be the policy of California Podiatry College Foot Clinic to accept for treatment all individuals in need of its services regardless of race, creed or color, excepting only those able to pay for services of a podiatrist in private practice."

The campaign within the profession for the new hospital has, to date (since January, 1960) produced $86,000. Less than ten percent of the pledgors live or practice within what might be termed hospital-user distance. The recommended pledge amount of $600 (not legally binding) to be paid at rate of $10 per month for five years, has been accepted by ninety-four percent of the subscribers.

Dr. Marvin Shapiro, President, American Podiatry Association, will be the featured lecturer at all sessions of the 14th Annual Seminar of the college. Dates and locations are: Salt Lake City, October 22, 23; Seattle, October 29, 30; San Francisco, November 5, 6; Los Angeles, November 12, 13.

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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Topics to be covered in the course, "Philosophy and Practice in Public Service," are: Pathways to Public Service; History, Development and Scope of Public Social Services; Referring Patients and Others for Agency Services; Public Health and the Responsibility of the Professional Person in Private Practice; The Philosophy of Federated Planning and Financing; The Role of the Healing Arts Professions in Serving Clients of Public and Private Agencies; Philosophy and Practice in Group Work and Recreation Services; The Philosophy of Religion in Social Service; The Role of the Professional Person in the Armed Forces of the United States; The Relationship of Professional People to Policies and Practices of Hospital and Clinic Operations; Philosophy and Practice in Family and Child Welfare Services; Community Planning for Better Health, with Case History and Public Relations for the Professional Person.

Facilities of the college, its hospital and clinic have been offered for use by the San Francisco Disaster Corps, American Red Cross, United Community Fund. Each accepted enthusiastically. Formal membership in the San Francisco Health Council now obtains.

FLORIDA

Appointment

Dr. R. A. Giudice, Gainesville, Florida, has been appointed Chairman of the American Red Cross "Fitness After Forty" program in Alachua County.

ILLINOIS

Dr. Jack Stern of Chicago, Membership Chairman of the Illinois Podiatry Society, was named President Elect of the American College of Foot Orthopedists at a meeting held in Chicago, August 28, as part of the 48th annual meeting of the A.P.A.

Dr. Fred G. Broun, President of the Illinois Podiatry Society, was recently appointed to the Subject Committee on Physical and Mental Health for the Illinois Conference on Aging, held in Springfield,

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September 6 and 7, in preparation for the White House Conference on Aging to be held in Washington next January.

Chicago College of Podiatry and Pedic Surgery

The Board of Directors of the Chicago College of Chiropody and Pedic Surgery announced the appointment of Herman G. Miller, D.S.C., as Dean. Dr. Miller has served on the faculty of the college since 1953, and was Administrator for the past 3 years. The office of Dean was left vacant by the death of Kurt L. Eichelbaum, M.D.

The Board, in further action, appointed Antoinette Thomas as Registrar. Mrs. Thomas has been serving in the administrative office for the past 3 years.

NEW YORK

National Health Agencies Report on Foot Care

A 4-page report on foot care has been prepared and released to all Federal installations in the New York area by the Federal Service Campaign for National Health

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SURGICAL KNIVES BY Rudolph Beaver

WALTHAM 54, MASSACHUSETTS

Agencies, Greater New York Committee.

The material in the report is based completely on data provided by the New York Society.

Extracts from this report shown below clearly indicate the recognition of the podiatrist as the foot specialist and the relationship of foot health to general health care.

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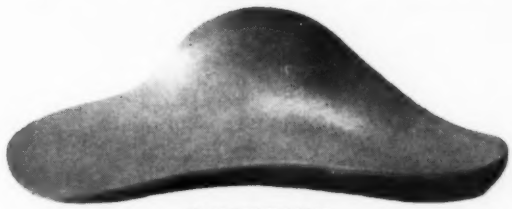

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OHIO

Ohio College of Chiropody
Zaccharian Research Society

The Zaccharian Research Society of the Ohio College of Chiropody wishes to announce that it is expanding its activities to include a program of participation from its alumni. This we hope to accomplish by the formation of an alumni association, to lend much-needed assistance for our more extensive research projects which are scheduled for the near future. All previous members will be contacted by mail with details.

To keep the alumni up to date on happenings within the Society and to keep it a close-knit organization dedicated to chiropodical research, a periodic newsletter will be sent to all members of the alumni association.

Last year's projects studied vaso-dilants and griseofulvin in oral, ointment and powder form.

The following officers were elected for 1960-61: President, Burton David; Vice President, Melvin Grovit; Secretary-Treasurer, Jack Levine.

PENNSYLVANIA

Berks County

Dr. Stephen P. Toth of Shenandoah, President of the Berks County Chiropody Society, presided at the initial meeting of

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the 1960-61 term held in Reading, September 6th, at the Berks County Medical and Dental Building. Other officers are: Dr. Lawrence Capozello, Jr., Vice President; Dr. Samuel Turrisi, Secretary; Dr. Mary A. Brown, Treasurer. Dr. Capozello was appointed Chairman of Arrangements for all the Scientific Sessions.

A copy of the film "Winged Foot," purchased from the American Podiatry Association, was shown. Dr. Toth stated that he has made arrangements for the showing of the film before two group and urged that all members make use of this film by showing it before organizations and other local groups as an Educational and Public Relations project.

Are you familiar with the savings possible through Association Insurance Plans?
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WOMEN'S AUXILIARY MESSAGE

Members of the Women's Auxiliary are ambassadors of good will for the Podiatry-Chiropody profession and in this role they work hard to implement programs designated to promote better foot health within every community throughout the nation.

Our new officers for the coming year are: 1st Vice President, Mrs. Fred Broun, Chicago, Illinois; 2nd Vice President, Mrs. Bruce Wright, Battle Creek, Michigan; Secretary-Treasurer, Mrs. Joy Adams, St. Petersburg, Florida.

As an affiliated organization of the A.P.A., our members stand ready to assist in any way we can to carry out the ideals and projects of the American Podiatry Association.

Mrs. Cleotha Parham
President

AMERICAN PODIATRY COUNCIL

The American Podiatry Council will hold a meeting on October 30, 1960, at the Barbizon Plaza Hotel, New York City.

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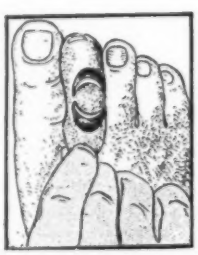
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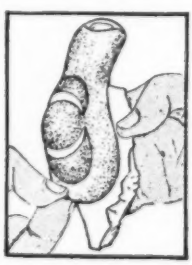
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ANNUAL MEETING GOLF TOURNAMENT

On a cloudy Monday morning a bus full of ardent golfers left the Drake Hotel and headed for Mohawk Country Club. But at 9:30 A.M. the sun was shining brightly as they were on the first tee. After an enjoyable round of golf and lunch, prizes and trophies were awarded. At 4:00 P.M. all but one made the bus and were on their way back to the Drake Hotel. Dr. Pat Stivers was in the shower when the bus left.

Much of the success of the tournament was due to the cooperation of the Golf Committee: R. Behrends, Evanston, Ill.; F. Benevento, Oak Park, Ill.; D. Cowell, Oak Park, Ill.; D. Hugar, River Forest, Ill.; H. Levin, Chicago, Ill.; M. Lewis, Chicago, Ill.; B. Jacobson, Chicago, Ill.; E. Peterson, Chicago, Ill., and J. Ristvey, Park Ridge, Ill.

Prize winners who were present at tournament to accept their trophies were (standing left to right), Mr. J. Besterman, Mr. H. Mitchell, Dr. A. Galantowicz, Dr. C. Hebert, Dr. D. Garcia, Dr. R. Carnes. (Front row left to right), Mr. W. Accamando, Dr. J. MacNicholas, Mrs. Olga Peterson, Mrs. Marge Carnes. Other winners, not present, were: Drs. R. Wysocki, A. Grieco, C. Hebert, E. Buchbinder and J. Tredway.

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Available ½ and ¼ oz. bottles complete with brush applicator.

Samples and literature on request. ®Trademark United States Rubber Company.

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COMMUNICATION FROM THE PROFESSION

To the Editor:

Among the activities of the Institute of Radio Engineers is the sponsorship of Professional Groups within its organization, of those particularly interested in a facet of the many and varied fields of the application of the science of electronics. The membership of the American Podiatry Association should have a particular interest in the Professional Group on Medical Electronics.

At the recent meeting of our association held at the Drake Hotel, Chicago, Ill., I noted the increasing part that electronic devices play in the practice of our profession. I was surprised that there was so little knowledge of this activity of the IRE, even among the salesmen demonstrating electronic apparatus.

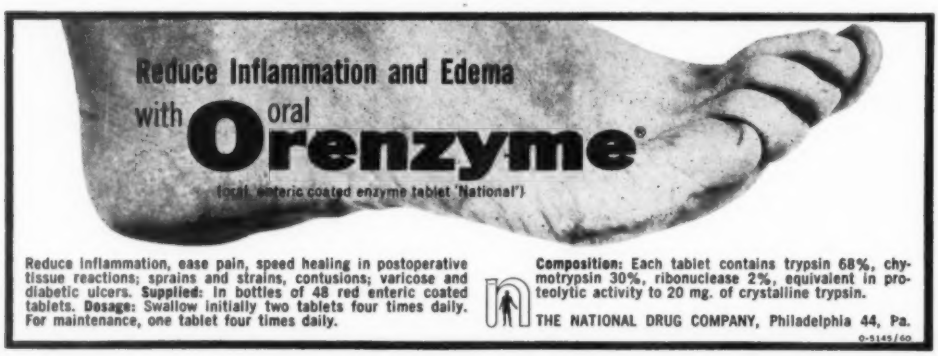
I have just received the July 1960 copy of the Supplement II to *The Bibliography on Medical Electronics,* prepared by The Medical Electronics Center of the Rockefeller Institute and published by the Institute of Radio Engineers. It is astonishing the extent to which electronics has penetrated into the medical profession. For instance, in this supplement alone there are 60 listings on ultrasonics. While the subject of many of these does not enter into our field, a quick scan over the list indicates that over half should be of interest to any one of us using ultrasonic devices. There are, of course, many articles listed on roentgen techniques, diathermy and other matters of great interest.

The July 1960 issue of the IRE *Transactions on Medical Electronics* includes some 25 papers and about half of them should be of direct interest to a practicing podiatrist. Without this IRE publication, I would never have become aware of the existence of these articles.

It is not necessary in many cases to belong to the IRE to participate in the activity of this Professional Group. The institute realizes that much of the useful material which it collects and publishes is not of general interest. (The technical material distributed to a member of the IRE during a single year will make a stack two feet high!) To meet this situation and to make the efforts of the institute of maximum benefit, an "Affiliate" program has been established. Under this, members of recognized societies (that is, recognized by the IRE) may join Professional Groups in which they have an interest without joining the IRE. They then receive only the technical material published in the interest of that group.

Through the Virginia Society, of which I am a member, steps were taken last spring to have the A.P.A. receive such recognition. At the time of this writing no action had been taken by the IRE. I hope that favorable action will be taken at an early date.

In the meantime any member of our association can do as I have done, that is, join the IRE as an Associate Member and simultaneously, join the Professional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Group on Medical Electronics. You will then receive all the material valuable to you and a great deal more. Your local library will welcome any material that is of no interest to you. The cost is modest considering the return. There is a registration fee of $3.00, IRE dues of $10.00 per year, (after five years of membership dues increase to $15.00 regardless of membership grade) and an annual assessment of $3.00 for membership in the Professional Group.

For complete information write to The Institute of Radio Engineers, Inc., One East 79th Street, New York 21, N. Y.

Marjorie M. Bunting, D.S.C.
St. Petersburg, Fla.

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Rodney H. Hilbert
Fullerton, Calif.

HOSPITAL SERVICE NEWS

NEW YORK

Buffalo Podiatrists Gain Full Hospital Staff Privileges

Dr. Harold Sarles of Buffalo and Dr. Merwin Adler of Tonowanda, New York, have been admitted to the staff of Doctors Hospital, an osteopathic hospital in Tonowanda, a suburb of Buffalo, and have full admitting and surgical staff privileges. The hospital is a 31-bed hospital with general medical and surgical facilities. Plans are being made for setting up a complete Podiatry Department. Association with the hospital has proven beneficial to the podiatrist, the osteopath and the patients.

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Abram L. Sachar, President
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CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Hartford, Conn., Oct. 21-23, 1960
Statler Hilton Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
New York, N. Y., Feb. 24-26, 1961
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 27-30, 1961
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Chicago, Ill., Mar. 17-19, 1961
Morrison Hotel
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood,
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Washington, D. C., Nov. 11-13, 1960
Shoreham Hotel
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E.,
Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

American Academy of Chiropodists
Canadian Podiatry Association
Joint Meeting
Toronto, Ontario, Canada, Oct. 23-24, 1960
Royal York Hotel
Dr. Charles E. Kelley
2488 Lee Rd., Cleveland Heights, Ohio
Dr. L. Hurwitz
3017 Bathurst St., Toronto, Ont., Can.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

Teacher: "Jimmy, if your father earned eighty dollars a week and gave your mother half, what would she have?"

Jimmy: "Heart Failure."

Bartender, to his boss: "I hope you hired that waitress you were interviewing."

"Yeah, I did," the boss replied. "She was a perfect 37-23-36-29."

The bartender was puzzled. "I can understand all but that 29. What does that mean?"

"That," sighed the owner, "was her I.Q."

Overheard at a Parent-Teachers meeting: "The most difficult thing about being a parent is trying to convince your kids that some day they will be as old-fashioned as you are now."

DR. POD by Bob Hughes

"It's something you ordered at the National Convention, Doctor!"

When the lady's car came to a sputtering stop in the gas station the attendant made a quick check and said, "Lady, your tank is bone dry."

"Oh dear," she moaned, "Will it hurt it to drive home that way?"

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Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1961.

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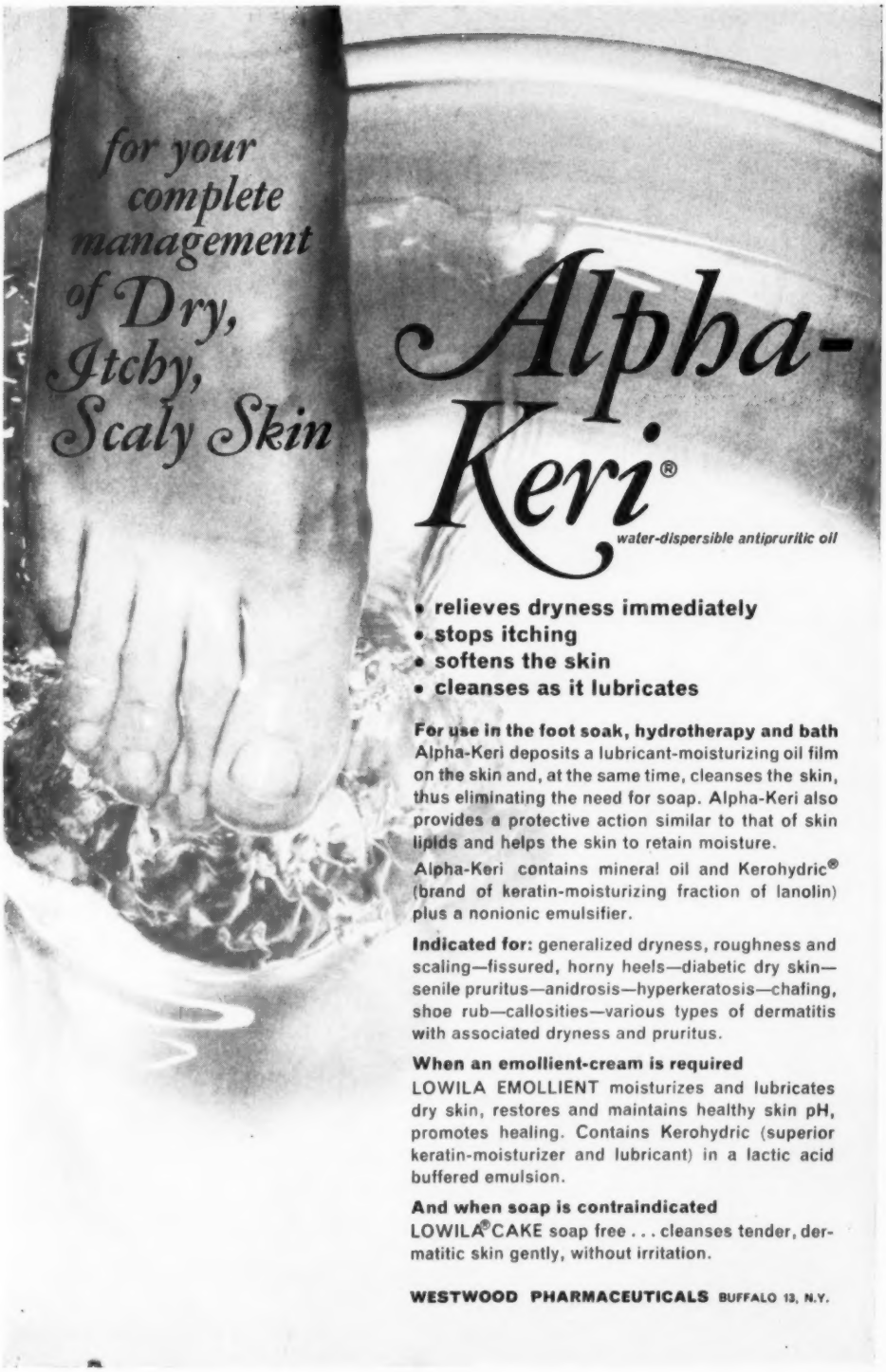
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